

King County Fiscal Evaluation Report

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Prepared by



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Introduction, Background and Methodology

In the spring of 2008, Emerald Consulting and Solutions Consulting Group (the Consultants) were invited to support the efforts of the King County Department of Community and Human Services, Developmental Disabilities Division (KCDDD), in the evaluation of all aspects of their finance system in their role as the local lead agency for the State of Washington's Infant and Toddler Early Intervention System (ITEIP), the Part C Early Intervention System.

The goal of this effort was to support KCDDD in the development of:

- A sustainable funding structure;
- Streamlined payment billing and reporting processes;
- Strategies to reduce administrative paperwork while maintaining accountability; and
- Recommendations for potential statewide policies that promote funding sustainability and accountability.

Working with the King County Fiscal Review Stakeholder Task Force, the Consultants examined all aspects of the current county early intervention funding structure and processes. The results of that examination are contained in this report, including recommendations to address the issues that were identified. It should be noted that it is unusual for either of these Consultant companies to work with local lead agencies. Our individual policies are that, should situations or requests to work with localities arise, the state Part C Lead Agency is contacted, understands and supports the contract work scope and anticipated outcomes, and is often a central participant in our consulting services. Each of these steps was assured in Washington State.

In the review of the financial system utilized by KCDDD to support Part C early intervention services, it is important to ground the process in the intent of Congress in establishing Part C. As identified in the regulations for Part C (§ 303.1 Purpose of the Early Intervention Program for Infants and Toddlers with Disabilities):

The Purpose of this part is to provide financial assistance to States to—

(a) Develop and implement a statewide, comprehensive, coordinated, multidisciplinary, interagency system that provides early intervention services for infants and toddlers with disabilities and their families;

(b) Facilitate the coordination of payment for early intervention services from Federal, State, local, and private sources (including public and private insurance coverage);

(c) Enhance State capacity to provide quality early intervention services and expand and improve existing early intervention services being provided to infants and toddlers with disabilities and their families;

(d) Enhance the capacity of State and local agencies and service providers to identify, evaluate, and meet the needs of all children, including historically underrepresented populations, particularly minority, low-income, inner-city, and rural children, and infants and toddlers in foster care; and

e) Encourage States to expand opportunities for children under three years of age who would be at risk of having substantial developmental delay if they did not receive early intervention services.

(Authority: 20 U.S.C. 1400(d)(2), 1431(a)(5), 1435(b))

The critical component for this financial evaluation is § 303.1(b) *Facilitate the coordination of payment for early intervention services from Federal, State, local, and private sources (including public and private insurance coverage)*. The intent of Congress in authorizing Part C as a coordinated, comprehensive interagency system was to recognize the many eligibilities that children and families bring to Part C. Rather than establish a separate program with separate funding, it was the intent of Congress that state Part C systems coordinate resources across existing programs and funding. Part C funds were intended to support required infrastructure and only support payment for early intervention services when no other eligibility was established.

As a consequence of the Congressional intent, states should not count on Federal Part C funds as a substantial source of direct service funding. It is the expectation of Congress that states will cultivate resources using the collective of Federal, state and

local resources – public and private – in developing, growing and sustaining a quilt of Part C supports and services, not all of them financially based.

Strategic Finance Framework

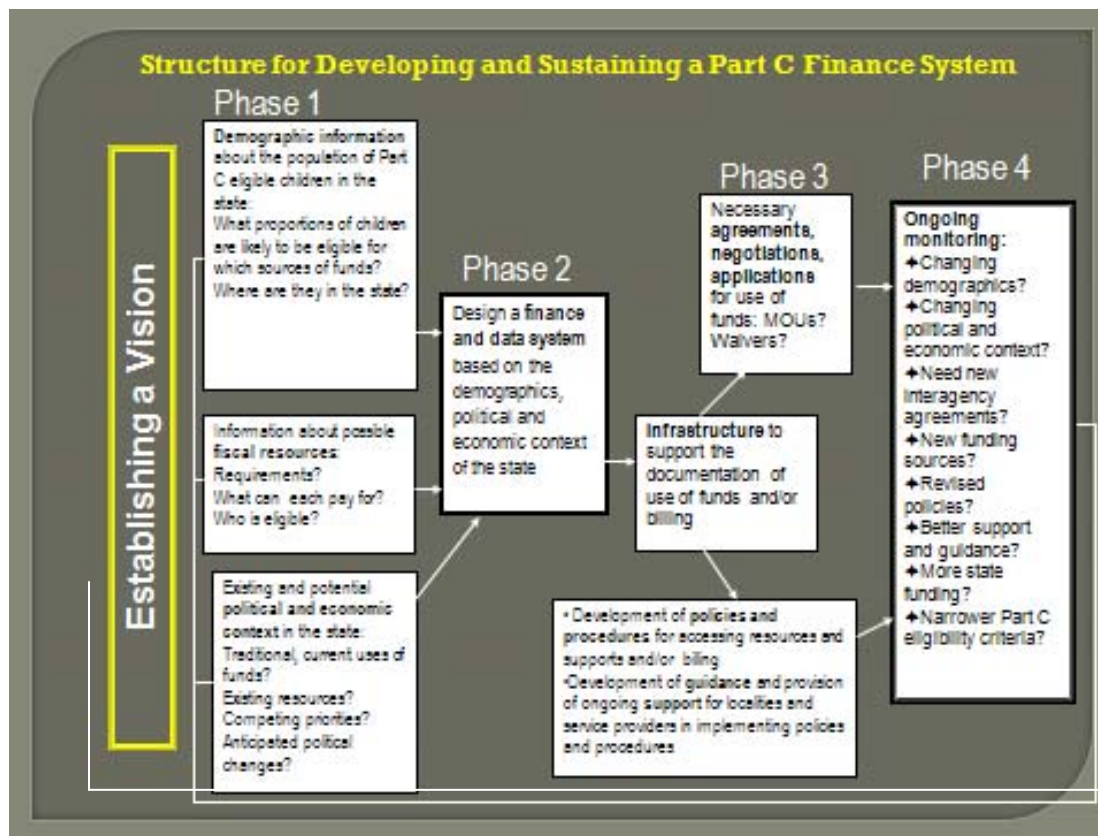
The Consultants proposed that the evaluation be conducted within the strategic finance framework. The framework requires the analysis of three (3) system elements:

- Demographic Information;
- Information regarding financial and programmatic resources and supports; and
- The political and economic context of the local area and state.

The finance framework provides an opportunity to systematically examine the children and families who should be served, the eligibilities that each child and family may bring to the Part C system, and the political and economic realities in which the system is involved. This framework allows states/local agencies to make informed decisions about the system they are responsible for based upon a comprehensive review of internal and external factors, coupled with extant data.

Historically, states have implemented Part C using the service delivery system that existed prior to Part C. Financing the system was also based in that historic model. Few states have engaged in a thoughtful, deliberate process of strategic planning that considered the federal intent of interagency collaborative programming and financing. Because of the lack of strategic finance planning, many states are experiencing the challenge of interagency finance and program silos in an era of fiscal crises.

Figure 1: Structure for Developing and Sustaining a Part C Finance System



The evaluation conducted by the Consultants, which is the subject of this report, initiated the strategic planning process that will need to be continued by KCDDD on an ongoing basis.

Prevalence Discussion

The importance of identifying the number of children that should be served in a state's Early Intervention System cannot be understated. The information related to the estimated prevalence rate is fundamental for ensuring:

- Benchmarks and planning;
- System design;
- Financing;
- Identifying resource and support needs;
- Quality assurance;

- Equity;
- Well being of children; and
- Long and short term service gap identification.

This simple question, with significant implications at both the state and national level, is quite complex and has recently been the target of several national studies indicating that 13% of children in the sample had developmental delays that would make them eligible for Part C early intervention¹.

An additional impetus for this information is the requirement of the Office of Special Education Programs (OSEP) that states evaluate the current percentage of children in service and establish a target to be served. Based on the December 1, 2007 Child Count, states serve an average of 2.53% of all children age 0 to 3 and 1.05% of all children below the age of 1 in Part C systems. While some states have believed that the national average was the target for all states, OSEP has been very clear that it simply represents the number of children in service and does not represent what should be. The OSEP directive is that each state must establish a unique target based on specific state conditions with consideration for each state's eligibility.²

As of September 1, 2008, King County has met the state target of serving 1.8% of the 0-3 population but at .48% is significantly below meeting the threshold of .80% for children under the age of 1. While OSEP has accepted the targets established by ITEIP in the State performance Plan, the targets are significantly lower than national research estimates. In the context of developing a sustainable finance framework, it is essential for planners to recognize that the statewide targets are simply too low.

¹ Prevalence of Developmental Delays and Participation in Early Intervention Services for Young Children; Steven A. Rosenberg, PhD, Duan Zhang, PhD, Cordelia C. Robinson, PhD, RN; Department of Psychiatry and JFK Partners, University of Colorado Denver, Denver, Colorado; College of Education, University of Denver, Denver, Colorado.
<http://pediatrics.aappublications.org/cgi/reprint/121/6/e1503>

² State Performance Plan Indicator 6: Percent of infants and toddlers birth to 3 with IFSPs compared to: A. Other States with similar eligibility definitions; and B. National data.(20 U.S.C. 1416(a)(3)(B) and 1442) " Measurable and Rigorous Target"

Methodology

The Consultants utilized a variety of qualitative and quantitative methods to review the King County finance system. The Consultants reviewed all finance and program data available through KCDDD including ITEIP, billing and payment and supplemental financial reporting. The review also included the contracting process with the county to obtain relevant data to adequately demonstrate compliance with the fiscal requirements of Part C.

Extensive discussions were conducted with county staff and state staff, as relevant. The Consultants formulated an interview process to be conducted with a representative sampling of contracted providers (e.g., public, private, small/large, discipline focused, etc.). These interviews were designed to understand how these functions are currently conducted, the current and potential capacity of the contracted providers to collect and report these data to the county, and options for streamlined, accurate and timely data collection. A series of questions were asked to gather relevant information that informed the fiscal issues. The questions are contained in Appendix A.

The Consultants conducted a vigorous review of contract language, policies and procedures and billing documentation and have provided comprehensive recommendations to KCDDD subsequent to this review. In addition, a review of service data (both planned and delivered) was conducted, as well as a review of state data and agency fiscal reports.

The King County Fiscal Review Stakeholder Task Force was pivotal to guiding the work of the evaluation. The Stakeholder Task Force was composed of diverse representatives, each with a knowledge base necessary to support the successful outcome. The Stakeholder Task Force supported the identification of a vision and desired outcomes for the process, the products and any subsequent systems improvements which would be recommended. The Stakeholder Task Force was involved throughout the process in order to establish and maintain the integrity and comprehensive nature of the evaluation.

In the course of the stakeholder process, the Consultants facilitated a discussion that focused on establishing a Vision for the King County ITEIP System. The Vision Statement often serves as the “touchstone” for decision makers as they contemplate systemic, practice or procedural changes as well as in the design, implementation and evaluation of subsequent changes.

The following Vision Statement was drafted from the variety of comments and ideas generated during the Stakeholder meeting.

Draft Vision Statement:

- o King County has a comprehensive, community based, interagency and multidisciplinary early intervention system which serves all eligible children from birth to three and their families. This system:
 - Is supported by a variety of resources from the federal, state, local, public and private levels;
 - Is a partnership between the provider community and families which emphasizes maximizing family strengths and competencies related to their child’s development in all domains through a variety of service options from which families may choose, emphasizing services and supports which support the child and family’s daily routines and activities;
 - Has a major role in enhancing child development;
 - Is accountable for the timely identification of eligible children, the responsive and respectful engagement of families, and the identification and delivery of services which are individualized, designed to meet the unique needs of eligible children and their families, and are provided by highly qualified and trained personnel;
 - Is accountable to decision makers, funding sources and the general public through the collection, analysis and reporting of accurate, factual and timely service and financial data, and for the proper expenditure of all funds regardless of source;

- Ensures that the system's finance resources don't unduly direct or limit families in terms of the services they may receive, the location or the provider they select; and
- Seeks to cultivate a seamless 0-5 system emphasizing prevention, intervention and early learning readiness.

Section 1: Data Analysis

Background

All providers delivering early intervention service for ITEIP are required to use the web based ITEIP Data Management System (DMS). While one provider in King County has worked through a process for uploading data to the ITEIP DMS, most providers submit data by direct data entry into the system. It is an early intervention data system managed at the state level in Olympia, and is focused primarily on meeting federal reporting requirements and on automating the Individualized Family Service Plan (IFSP). ITEIP DMS is not, by design, a billing system. Also, this review preceded an upgrade to the ITEIP DMS which may have addressed some of the following concerns. It will be important to review the data after some period of using the upgraded system to verify that the changes did in fact have the intended impact. For example, making some fields required without a companioned change to drop down lists will create a very limited positive change in the system.

In addition to the ITEIP DMS, KCDDD is in the midst of developing an in-house data system for financial management functions to replace the complex set of Microsoft Excel sheets used for financial management. It is essential that this new system work together with the programmatic data in order to assist with day-to-day management and long-term planning for early intervention services in King County. Today's ITEIP financial system, a complex series of Excel spreadsheets, is limited to the sources of funds which flow through King County government. The system does not account for more than half of the revenue which currently pays for ITEIP throughout the county.

Based on Consultant review, the level of data available within ITEIP presented an opportunity for analysis that could assist the scope of this project. An ad hoc data

request was prepared by the Consultants in May and reviewed with KCDDD staff and state level personnel in Olympia. The data were subsequently delivered in July. Cautions about the accuracy and integrity of the data came from many directions including KCDDD staff and providers who routinely use the system. Despite the cautions, the Consultants felt it was important to independently assess the data since it is an integral part of Washington State's early intervention system and, as in many other states, it serves as the foundation for financial planning. In the end, only limited portions of the data could be used to support this study due to the data challenges identified below.

ITEIP Data System Challenges/Concerns

1. The ITEIP DMS use of open text fields rather than defined lists, especially for provider, frequency, Intensity and method, makes the data impossible to aggregate without first building a crosswalk to form some consistent responses. Without consistency, the data can only be viewed as a single unique entry and cannot be aggregated for any helpful management reporting.
2. Fields like frequency and intensity should not only have a consistent format but one should also be required, especially since these fields are legally required as part of the source document.
3. Working with the data was particularly challenging since the application does not allow for lookup with the Child Identification Number. As part of protecting personally identifiable data, the Consultants worked only with child identification numbers and could not help providers with the review process without asking KCDDD officials to provide the child name.
4. A primary outcome of ITEIP DMS is an electronic IFSP that can be printed and given to families. The irregularities with the formatting of the printed IFSP is of concern to many providers; at least half of the providers in King County report using a word processor program to create a more family friendly document. This takes an additional hour to hour and a half on top of the original ITEIP data entry process.
 - a. An unusual component of the ITEIP DMS includes the entry of the entire IFSP document including all of the narrative. Of the dozen or more

systems that these Consultants have worked with, none have included all of the components of this lengthy document. The benefit of this laborious task seems unclear.

- b. Additionally, the number of misspelled words is significant. Counsel should be provided on either the use of spell check when available or a second level of review should occur to mitigate the level of spelling errors.
5. The Consultants would encourage the use of date fields rather than “yes/no” items since “yes/no” does not provide for any time reference. The same effort can be accomplished with more information by using a date to confirm when something happened rather than a “yes” in the data field.
6. The database operates using an encrypted database requiring an extraction in order to do anything outside of the system-developed reports. It is a cumbersome process in that a request must be made, approved and then executed. This process typically takes 4-6 weeks.
 - a. The extraction resulted in multiple lines of the same service but with different fund sources.
 - b. Providers also create multiple lines for a single service by data entering the same service for each unique outcome.
 - c. Amendments also create multiple entries without making clear the effective dates and properly altering the original service line.
7. The system has no prepared reports that work with the IFSP service detail.
8. Most, if not all, agencies report using a different database for operations and billing including the KCDDD administration because there is no ability to link delivered services to planned services detailed in the IFSP. The encrypted nature of the statewide database and the cumbersome process for data extraction limit the long-term viability of this kind of important interface.
9. There is a lack of consistency in how data is entered from program to program, especially around IFSP amendments.
 - a. The inconsistency in the entry of IFSP amendments process is substantial. Only one (1) provider reported using the amendments process within the ITEIP DMS. Most King County providers either do not enter them at all or use an alternate method for reporting amendments.

10. The amount of data entry time reported is about an hour and a half for each IFSP. Based on King County data from October 2007 through September 2008 (Table 1), King County providers reported completing 2,136 IFSPs and 1,312 new or initial IFSPs for a total of 3,448 documents, requiring an estimated 5,172 hours of data entry. At an estimated cost of \$25 for a fully burdened hour, it is estimated that annual data entry costs are estimated at \$129,300.
11. Providers using the ITEIP DMS who were interviewed by these Consultants presented a very consistent and universal dislike of the system.

Recommendations

Quantitative data is an essential component for managing the day to day operations of King County ITEIP, a system with an estimated \$15 million dollars of annual costs using today's limited information.

Recommendation 1.1:

The Consultants recommend use of the Client Tracking system developed by Data System International. This system is already in use with Pierce County and is being considered in Snohomish County, both of which also contract with KCDDD contracted early intervention agencies. KCDDD would hold the responsibility for the required interface to the State's ITEIP DMS. The process will have been established by Pierce County so that the effort should be already developed.

Recommendation 1.2:

Also important will be the development of an interface between ITEIP DMS and the new finance system being developed in-house with KCDDD Government. While providers may not abandon the need to maintain independent systems, it would allow providers a more likely opportunity for some forms of electronic interface.

Recommendation 1.3:

IFSP data, to include specific services, frequency and intensity, and funding source must be current regardless of the system in use.

- Recommendation 1.4 New data must be entered and routinely updated, including updates as the fund source information is confirmed, and whenever

services are changed from the existing IFSP (added, increased, decreased or terminated).

- o An example of this would be for the child who is Medicaid-enrolled. Physical Therapy, Speech Language Pathology and Occupational therapy would be reimbursed by Medicaid while Special Instruction would be Child Development Services (CDS) or other local funds.
- o Another example would be when private insurance is used for a period of time (e.g., 10 treatments) and then CDS funds are used. This level of detail, including timely and accurate entry, is essential to ensure proper tracking, planning and monitoring.

Report Month =		Oct-07	Nov-07	Dec-07	Jan-08	Feb-08	Mar-08	Apr-08	May-08	Jun-08	Jul-08	Aug-08	Sep-08
The day the report was run =		Nov. 26, 2007	Dec. 18, 2007	Jan. 18, 2008	Feb. 21, 2008	April 08, 2008	April 23, 2008	May 23, 2008	July 02, 2008	July 21, 2008	Aug. 21, 2008	Sept. 18, 2008	Oct. 21, 2008
King	<i>Number of Referrals made during the month</i>	117	76	42	103	116	89	106	138	66	79	40	86
	<i>Number of Evaluations to Determine Eligibility</i>	112	101	76	101	118	109	136	156	117	111	90	109
	<i>Number Determined Eligible during the month</i>	100	107	68	104	111	98	117	149	118	102	85	103
	<i>IFSPs Completed During the Month</i>	181	165	129	181	175	196	153	214	199	198	142	203
	<i>Number of New/Initial IFSPs completed during month</i>	97	110	83	102	106	114	104	145	131	116	100	104
	<i>Active IFSPs on last or first (for Dec. 1) day of month</i>	1036	1051	1059	1069	1095	1135	1169	1234	1275	1257	1258	1259
	<i>Total number of children served within month</i>	1120	1145	1132	1160	1182	1215	1252	1331	1379	1389	1361	1373
	<i>Children Transitioned within month</i>	72	74	38	84	75	58	63	93	85	103	81	85

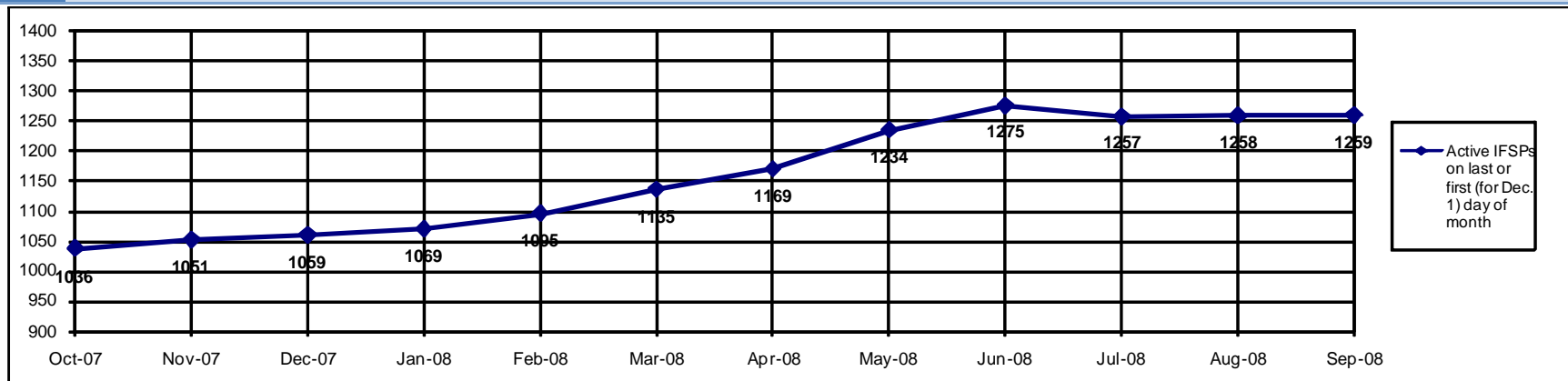


Table 1: King County Data October 1, 2007 through September 30, 2007

[HTTP://WWW1.DSHS.WA.GOV/ITEIP/FFY2008CONTRACTDATA.HTML](http://www1.dshs.wa.gov/iteip/ffY2008contractdata.html)

Section 2: Part C System of Payments/Financing Requirements

Federal Part C regulations under the IDEA establish the early intervention system as one with interagency collaboration and partnerships at its core. This is the first piece of Federal legislation to assign responsibility for resources, services and supports to Federal programs beyond the direct purview of the sponsoring agency – in this case, the U.S. Department of Education.

A comprehensive array of regulations create the opportunities for interagency funding and service collaboration across approximately 40 Federal and state resources. Each state is required to articulate a System of Payments that ensures the availability of services to eligible children and their families through interagency agreements and other formal mechanisms that ensure the protections for the family's inability to pay, payor of last resort (POLR), nonsupplanting and maintenance of effort (MOE).

Sec. 303.522 Identification and coordination of resources.

(a) Each lead agency is responsible for--

(1) The identification and coordination of all available resources for early intervention services within the State, including those from Federal, State, local, and private sources; and

(2) Updating the information on the funding sources in paragraph (a)(1) of this section, if a legislative or policy change is made under any of those sources.

(b) The Federal funding sources in paragraph (a)(1) of this section include--

(1) Title V of the Social Security Act (relating to Maternal and Child Health);

(2) Title XIX of the Social Security Act (relating to the general Medicaid Program, and EPSDT);

(3) The Head Start Act;

(4) Parts B and H of the Act;

(5) The Developmental Disabilities Assistance and Bill of Rights Act (Pub. L. 94-103); and

(6) Other Federal programs.

(Approved by the Office of Management and Budget under control number 1820-0550)

(Authority: 20 U.S.C. 1435(a)(10)(B))

[58 FR 40959, July 30, 1993, as amended at 63 FR 18296, Apr. 14, 1998]

The Part C/IDEA System of Payments has been historically referenced when a state has some form of family cost participation (e.g., family fee and/or the use of private insurance). For the purposes of this Report, we are intentionally defining the term – System of Payments – more broadly than family fees to include ALL current and potential Part C resources. We do this because of the current practices of the State of Washington related to family co-pays and deductibles with respect to the utilization of private insurance and the inherent public policy issues related to this state policy.

There is a natural interaction between family resources and the variety of Federal, state and local funding resources that need to be considered as states implement the Part C funding hierarchy. This hierarchy includes programs and services which provide or pay for a variety of services and supports for very young children and their families, and is based primarily upon child eligibility and program relationships as established in a variety of Federal regulations and statute.

Use of Existing Resources

Figure 2 illustrates the variety of resources, supports and services; a significant majority of which are utilized by **at least one state** in their Part C system.

*A Framework for Developing and Sustaining a Part C Finance System*³ (Greer, Taylor, Mackey Andrews), summarizes the original intent of the Part C funding from Congress:

“Typically, Federal entitlement statutes reflect a traditional program approach, with separate program funds attached to the legislative intent. The Part C provisions of PL 99-457, the Individuals with Disabilities Education Act (IDEA), however, were envisioned by Congress in an unprecedented manner. Part C legislation was designed to establish an interagency, coordinated system of resources (including finance), supports and services, with financing attached to the legislation that reinforced this approach. Part C funds were uniquely designated to support the development and maintenance of a coordinated infrastructure and “to facilitate the coordination of payment for early intervention services from Federal, state, local and private sources

³ <http://nectac.org/pubs/titlelist.asp#financeframework>

(including public and private insurance coverage).” The financial crisis that faces state lead agencies today is the gap between Congressional intent and current reality.”

This paper provides an in-depth study of the regulatory framework of Part C and is a good source for Part C system background information for readers of this Report.

In utilizing the variety of resources possible, the State Lead Agency will need to understand and adhere to the respective “rules” governing other funding sources. It must work carefully to integrate resources and establish reporting abilities that not only are responsive to OSEP reporting requirements, but to other agency and source requirements. The broad array of resources extends beyond the Department of Education Part C regulations and the Education Department General Administrative Regulations (EDGAR)⁴, and implicitly involves Medicaid/Title XIX, Title V Maternal/Child Health (MCH) and Children with Special Health Care Needs (CSHCN), Part B/IDEA, Head Start, etc. (Sec. 303.522 Identification and coordination of resources.)

Because of the regulatory and program complexities, state Part C Lead Agencies may “admire” some funding or programmatic sources and elect not to utilize them in the Part C “quilt,” primarily because they do not support the principles, values, tenets or vision for their early intervention system.

Of particular note and importance are the requirements of EDGAR since they affect the financial and programmatic aspects of the Part C system at all levels. It is imperative that Part C administrators and grant recipients are conversant in EDGAR requirements and that these requirements are incorporated into program policies, procedures and documentation.

Federal Part C regulations expressly exempt Part C revenue from public and private insurance under EDGAR §80.25, which requires that program revenue be deducted from Federal grant funds. All other EDGAR requirements apply to Part C. To highlight

⁴ <http://www.ed.gov/policy/fund/reg/edgarReg/edgar.html>

the importance of EDGAR, we are highlighting a few key financial requirements which affect program activities specifically.

Key requirements for KCDDD under EDGAR with respect to financial management and reporting include, but are not limited to:

Sec. 74.24 Program income.

(a) The Secretary applies the standards contained in this section in requiring recipient organizations to account for program income related to projects financed in whole or in part with Federal funds.

(b) Except as provided in paragraph (h) of this section, program income earned during the project period must be retained by the recipient and, in accordance with ED regulations or the terms and conditions of the award, must be used in one or more of the following ways:

(1) Added to funds committed to the project by the Secretary and recipient and used to further eligible project or program objectives.

(2) Used to finance the non-Federal share of the project or program.

As such, program income must be used for Part C purposes and not redirected to other programs or populations. This section does have implications particularly in Part C systems where contracted providers are utilized and accountability is not readily transparent through routine financial reports including detailed expenditure statements. The recent enhancements made by KCDDD in quarterly program reporting identify individual sources of a variety of revenue.

Other sections of EDGAR we wish to highlight are §74.34 and §80.32 which require that equipment purchased with Federal funds is the property of the recipient program and must be inventoried at least every two (2) years. For the purposes of this discussion, equipment means Assistive Technology devices that are not expendable. This equipment must be used by the recipient program under the general purposes of the grant funds, and may be transferred to other Federal programs if there is no longer a need for the equipment within the original receiving programs. There are multiple opportunities for financing Assistive Technology and if public or private insurance is used to fund Assistive Technology, this equipment is then owned by the family. If Federal Education dollars are used for the purchase of equipment, the EDGAR sections discussed above apply and, as the child exits the Part C system, disposition of this

equipment must be part of the formal transition planning. There is the suggestion in at least one OSEP state letter⁵ that it may be possible for equipment to transition from the Part C system to Part B without any exchange of funds. These practices would be reflected in the state interagency agreement. Other disposition options include the family surrenders the equipment to the Part C system, or the receiving Part B system or family may purchase the equipment based upon reasonable depreciation.

⁵ Letter to Susan Goodman, Assistive Technology Funding and Systems Change Project, June 21, 1998

Figure 2: Resources, Supports and Services for Part C

Federal Fund Source	State Fund Source
0 to 3 Part C/IDEA	Medicaid EI System State Match
Part B – Section 619/IDEA	State Part C Appropriation
Part B – Section 611/IDEA	Title V / MCH and/or CSHCN State Funds
Medicaid Administrative Claiming Agreement	State Maintenance of Effort (TANF) funds
Medicaid (XIX) – regular	Part B - Section 619 - State Funds
Medicaid (XIX) – EPSDT	Part B Special Education State Funds
Medicaid – waiver program	MHMR Funds
Medicaid - managed care carve out	Healthy Families Initiative
Medicaid - managed care	Early Head Start
Medicaid –Targeted Case Management	Head Start
S-Chip (Title XXI)	HMO/PPO/IPA (private managed care)
Title V – MCH	State Regular Education Funds
Title V – CSHCN	
CHAMPUS/TRICARE	
Impact Aid/DOE (military, Native American)	
Women, Infants and Children (WIC) Nutrition Program	
Early Start	
Early Head Start	
Head Start	
Title XX SSBG	
CCDBG/CCDF	
Family Preservation Funds/Services	
Dropout Prevention Funds	
Prevention of Juvenile Justice Funds	
Title IV-A/TANF	
Title IV-B	
Title IV-E	
	Local Fund Sources
	Parents as Teachers/Parent Training Programs
	Private Insurance/HMO/PPO/Indemnity
	Locally Raised Tax Revenue
	Provider Contributions
	Local Part B-Section 619 Funds
	Local Part B Special Education Funds
	Local Part B Regular Education Funds
	Local County MRDD Funds
	Locally Raised Revenue Contributions

There is a natural interaction between family resources and the variety of Federal, state and local funding resources that need to be considered as states implement the Part C funding hierarchy. This hierarchy includes programs and services which provide or pay for a variety of services and supports for very young children and their families, and is based primarily upon child eligibility and program relationships as established in a variety of Federal regulations and statute.

Figure 3: Child and Family Eligibilities

Family Cost Participation including Co-Pays, Deductibles, Sliding Fee Payments
Private Insurance S-CHIP/Title XXI TRICARE (formerly CHAMPUS)
Medicaid – Title XIX
Children with Special Health Care Needs (CSHCN) – Title V/MCH
Temporary Assistance to Needy Families (TANF)/Title IV-A
Child Welfare/Title IV-E
Other Federal Fund Sources
Other State and Local Fund Sources
State Part C Funds
Federal Part C Funds
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As states refine their implementation of Part C of the IDEA, greater collaboration with other infant and early childhood services, health and medical care, social services and community service entities is increasing. These partnerships work together to build strong and vital comprehensive early childhood systems which serve all children regardless of the child's developmental status, family income, education or residence. We can credit this to several factors:

- o State Part C systems focusing their efforts on locating and identifying all eligible children, and providing services and supports needed to enhance the family's capacity to respond to the developmental needs of their child.
- o State Part C systems are implementing services and supports emphasizing the typical routines and activities of the very young child and family, involving more home and community based partners such as child care, Early Head Start, parenting programs, etc.

- o Efforts to focus on earlier identification have broadened the child enrollment to include more diverse populations, including children in the child welfare system (CAPTA⁶), infants in high risk nurseries, families with very young children who are homeless, etc.). These efforts have also expanded the need for more diverse supports and services, given the multiple needs of infants, toddlers and families.
- o Parallel regulations in other Federal programs, such as Head Start, Title V, Title XIX, reinforce the funding hierarchy and create expanded avenues for partnership at the state level by confirming these third party resources as “payors of first resort” for dually enrolled children.

The landscape of early childhood services is changing rapidly, with increased Congressional and state legislative focus on creating and expanding services for the infant, toddler and preschool populations in general, often linked to economic development initiatives. Partnerships through Early Head Start and Head Start, prevention programs focusing on parent education and support, the cultivation of universal pre-K programs, greater emphasis on well child care and the medical home are only a few examples of what many view as a “perfect storm” of opportunity for state and local leaders in the field of early childhood.

These general early childhood and family resources help to ensure that families have the opportunity for themselves and their child to participate in community programs that they would typically be eligible for. These partnerships also help to support the Part C system in their obligation to address the whole family and child needs, and effectively build disability and developmental delay issues into and within the general early childhood system of a state.

In planning system improvements related to financing for early childhood and family supports and services, there are multiple issues which must be considered. In order to ensure that all resources are effectively utilized, supports and services to eligible children and families should:

⁶ Child Abuse Prevention and Treatment Act

- be cultivated or improved in terms of accessibility and utilization,
- “match” or conform to the population to be served,
- be consistent with the method or desired approach(es) to providing services,
- expand and support the variety and availability of appropriately trained and qualified providers,
- be compatible with how data will be collected and verified, and
- facilitate service monitoring and supervision to ensure timeliness, quality and compliance.

Figure 4 illustrates the six (6) different criteria which are used to establish eligibility for services and/or funding by a variety of Federal, state and local resources. Sometimes multiple criteria are utilized, such as child age and family income. As such, children will have a greater likelihood of “multiple eligibilities,” requiring coordination between resources to ensure that the funding hierarchy is honored, and that POLR, nonsupplanting and/or MOE can be assured.

Figure 4: Eligibility Criteria

CHILD AGE (0-3, 0-5, 0-21, etc.) Lifespan Considerations	DIAGNOSIS OR DISABILITY
INCOME/FEDERAL POVERTY LEVEL	TYPE OF SERVICE OR SUPPORT
DEGREE OR LEVEL OF NEED	POPULATIONS OF SPECIAL CONSIDERATION

Family Cost Participation (FCP): Family Fees and Third Party Public/Private Insurance

Family Cost Participation is a process widely used by states to provide a statewide, standardized way in which family fees for some or all of the Part C IFSP services are assigned based upon selected variables (family income being the most common). States must integrate their policies and procedures on the use of private insurance together with FCP in light of the “cost” involved in co-payments and deductibles when private insurance is used to support an IFSP service(s).

Sec. 303.521 Fees.

(a) General. A State may establish, consistent with Sec. 303.12(a)(3)(iv), a system of payments for early intervention services, including a schedule of sliding fees.

(b) Functions not subject to fees. The following are required functions that must be carried out at public expense by a State, and for which no fees may be charged to parents:

(1) Implementing the child find requirements in Sec. 303.321.

(2) Evaluation and assessment, as included in Sec. 303.322, and including the functions related to evaluation and assessment in Sec. 303.12.

(3) Service coordination, as included in Secs. 303.22 and 303.344(g).

(4) Administrative and coordinative activities related to--

(i) The development, review, and evaluation of IFSPs in Secs. 303.340 through 303.346; and

(ii) Implementation of the procedural safeguards in subpart E of this part and the other components of the statewide system of early intervention services in subparts D and F of this part.

(c) States with mandates to serve children from birth. If a State has in effect a State law requiring the provision of a free appropriate public education to children with disabilities from birth, the State may not charge parents for any services (e.g., physical or occupational therapy) required under that law that are provided to children eligible under this part and their families.

*(Approved by the Office of Management and Budget under control number 1820-0550)
(Authority: 20 U.S.C. 1432(4))*

There are a myriad of issues related to assigning family cost, not the least of which is the assignment and collection of fees, the integration of fees together with the co-pays and deductibles related to the use of private insurance, and the need to have meaningful procedures related to the inability vs. refusal to pay.

Family fees may be assigned on an individual service basis, or may be a total fee assigned annually which may or may not have some relationship to the services on the IFSP.

Resource coordination includes state's use of family resources such as public and private insurance and family fees to meet the Part C requirement re: "inability to pay." Some state Part C systems employ a process called "financial case management" or "resource management" which is a service coordination activity that helps to inform and educate the family about the variety of resources that are available so that they

utilize appropriate resources when possible and have this information with them as they “age” into other systems of care.

This resource coordination is particularly important when a state’s Part C system utilizes the family’s private insurance in the payment for any Part C service. Federal Part C regulations provide the ability for states to access a family’s private insurance coverage with their informed, written consent, and to ensure that the requirement that family “inability to pay” has been identified and protected. Because co-payments and deductibles are implicit in the access of private insurance, issues of family cost and “inability to pay” apply when private insurance is accessed.

The last round of Federal IDEA Part B regulations protected the access to public insurance by requiring family consent in order to access these resources. We have no reason to believe that anything less than this will appear in the Part C regulations when these regulations are published. State Part C systems commonly utilize the “at no cost” definitions from Part B of the IDEA when crafting public policy related to utilization of private insurance; that is, “cost” which would result in 1) loss of insurance coverage in whole or in part, 2) escalation of premium, co-pays or deductibles, or 3) erosion of the life-time benefit “cap.”

As changes continue to be made to Medicaid program at the Federal and state level (e.g., managed care, the DRA), KCDDD administrators are cautioned to ensure that each family’s “inability to pay,” regardless of the public and/or private mix of financing used to support IFSP services, is protected. This resource blending as occurs in Washington State requires a “system of payments” that incorporates the “inability to pay” principles as well as consideration of the funding hierarchy and the related fund-source regulations.

A few states have developed and promulgated “insurance legislation” which creates special provisions for private insurance related to Part C, often eliminating inclusion of covered-Part C services from the lifetime benefit cap, or establishing an annual maximum benefit in order to manage the cost to the third party insurer. Absent this kind of legislation, states which utilize either public and/or private insurance must adhere to the regulations governing these resources. These requirements typically include the obligation to collect co-payments and deductibles, and hold the provider to their contractual commitment to accept this as “payment in full” for services rendered. Other requirements are often found in limits of service, provider enrollment qualifications or limitations, site of service, etc.

Private insurance payments are made against individual units of (e.g., 15 minute increments) service for specific, covered services. Medicaid reimbursement is generally the same, although there are some situations where the Medicaid payment unit is more global (e.g., one month or one episode), although this is largely discouraged by the Centers for Medicare and Medicaid Services (CMS) since the passage of the Deficit Reduction Act (DRA).

Part B, IDEA Funds

Some states utilize Part B federal and/or state funds in their Part C system. These funds may be found in one or more of the system components, or in direct services. In Washington State, state education funds flow on an annualized basis for children served in Part C during the traditional school calendar year. These dollars are capitated, and range from locality to locality in terms of their amount and distribution method.

In Summary

Resources will vary within and across the counties in any state based upon county demographics and will vary due to the significant, individualized character of county resources. Excluding demographics, which can be easily managed by rigorous and frequent data review, the variations of eligibility and resources makes it more challenging to create a “statewide” system of payments that includes all resources.

The distribution of funds under the authority of any state's Lead Agency should be proportionately allocated based upon a combination of demographics and consideration of third party resources, including Medicaid, private insurance and family fees. Measures should be incorporated to encourage local contributions (local county funds and agency partnerships) through incentives that promote utilization of third party opportunities. Historical enrollment data is useful, particularly when used in a trend analysis format, in crafting and evaluating an allocation formula. The Lead Agency's distribution of Federal and state resources (if available), should promote utilization of all third party resources by establishing this as an incentive within the formula itself.

Payor of Last Resort (POLR)

POLR requires that all other fund sources are used before federal Part C funds are tapped to support direct services. Some states have extended this POLR requirement to include state general funds as well. The State is required to have formal interagency agreements that define the financial responsibility of each agency for paying for early intervention services (consistent with State law) and procedures for resolving disputes and that include all additional components necessary to ensure meaningful cooperation and coordination.

Sec. 303.527 Payor of last resort.

(a) Nonsubstitution of funds. Except as provided in paragraph (b)(1) of this section, funds under this part may not be used to satisfy a financial commitment for services that would otherwise have been paid for from another public or private source, including any medical program administered by the Secretary of Defense, but for the enactment of part C of the Act. Therefore, funds under this part may be used only for early intervention services that an eligible child needs but is not currently entitled to under any other Federal, State, local, or private source.

(b) Interim payments--reimbursement.

(1) If necessary to prevent a delay in the timely provision of services to an eligible child or the child's family, funds under this part may be used to pay the provider of services, pending reimbursement from the agency or entity that has ultimate responsibility for the payment.

(2) Payments under paragraph (b)(1) of this section may be made for--

(i) Early intervention services, as described in Sec. 303.12;

(ii) Eligible health services (see Sec. 303.13); and

(iii) Other functions and services authorized under this part, including child find and evaluation and assessment.

(3) The provisions of paragraph (b)(1) of this section do not apply to medical services or "well-baby" health care (see Sec. 303.13(c)(1)).

(c) Non-reduction of benefits. Nothing in this part may be construed to permit a State to reduce medical or other assistance available or to alter eligibility under title V of the Social Security Act (SSA) (relating to maternal and child health) or title XIX of the SSA (relating to Medicaid for children eligible under this part) within the State. (Approved by the Office of Management and Budget under control number 1820-0550) (Authority: 20 U.S.C. 1440)

Note: The Congress intended that the enactment of part C not be construed as a license to any agency (including the lead agency and other agencies in the State) to withdraw funding for services that currently are or would be made available to eligible children but for the existence of the program under this part. Thus, the Congress intended that other funding sources would continue, and that there would be greater coordination among agencies regarding the payment of costs. The Congress further clarified its intent concerning payments under Medicaid by including in section 411(k)(13) of the Medicare Catastrophic Coverage Act of 1988 (Pub. L. 100-360) an amendment to title XIX of the Social Security Act. That amendment states, in effect, that nothing in this title shall be construed as prohibiting or restricting, or authorizing the Secretary of Health and Human Services to prohibit or restrict, payment under subsection (a) of section 1903 of the Social Security Act for medical assistance for covered services furnished to an infant or toddler with a disability because those services are included in the child's IFSP adopted pursuant to part C of the Act.

[58 FR 40959, July 30, 1993, as amended at 63 FR 18296, Apr. 14, 1998]

The POLR for each child and family will vary given their various eligibilities and resources which they bring to the Part C "table." The reader can see the interface between POLR and "inability to pay," which may -- with justification based upon parent consent -- remove some resources from use by Part C depending upon their "cost" to the family.

Nonsupplanting/Maintenance of Effort (MOE) Requirement.

The State Lead Agency for Part C must ensure and demonstrate to OSEP that Part C federal funds are not being used to replace current resources in the system, including but not limited, in Washington State, to CDS or other public funds at the local level.

Sec. 303.124 Prohibition against supplanting.

(a) The statement must include an assurance satisfactory to the Secretary that Federal funds made available under this part will be used to supplement the level of State and

local funds expended for children eligible under this part and their families and in no case to supplant those State and local funds.

(b) To meet the requirement in paragraph (a) of this section, the total amount of State and local funds budgeted for expenditures in the current fiscal year for early intervention services for children eligible under this part and their families must be at least equal to the total amount of State and local funds actually expended for early intervention services for these children and their families in the most recent preceding fiscal year for which the information is available.

Allowance may be made for--

(1) Decreases in the number of children who are eligible to receive early intervention services under this part; and

(2) Unusually large amounts of funds expended for such long-term purposes as the acquisition of equipment and the construction of facilities.

(Approved by the Office of Management and Budget under control number 1820-0550)

(Authority: 20 U.S.C. 1437(b)(5)(B))

[58 FR 40959, July 30, 1993, as amended at 63 FR 18294, Apr. 14, 1998]

Further, each State is required to ensure that the Federal Part C funds will not be commingled with State funds; and will be used to supplement the level of State and local funds expended for infants and toddlers with disabilities and their families and in no case to supplant those State and local funds.

Federal Part C Fiscal Monitoring

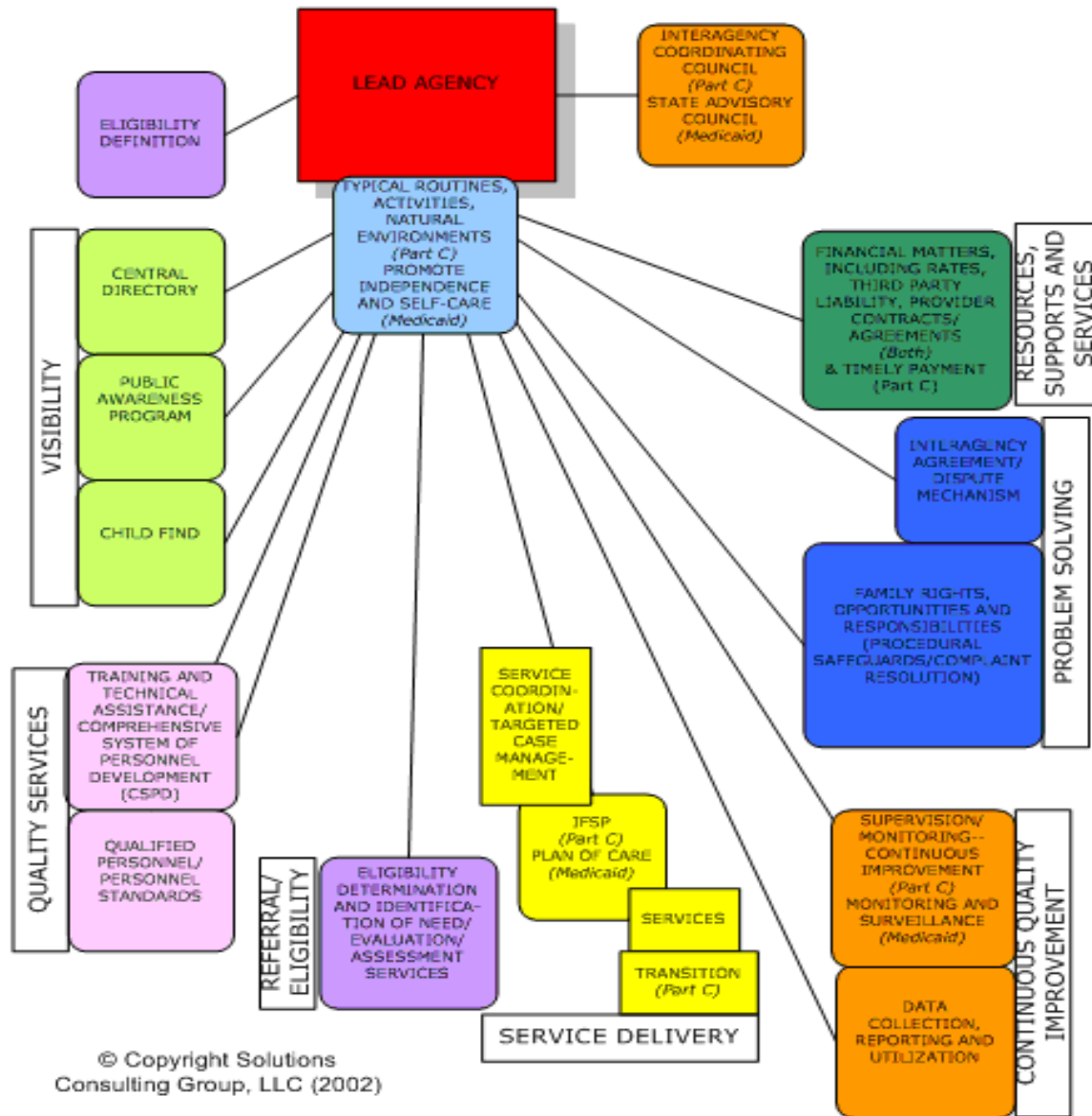
Fiscal monitoring protocols have been developed and incorporated into the overall OSEP Part C monitoring, requiring states to actually demonstrate how they meet the federal regulatory requirements related to finances. The Critical Elements Analysis Guide (CrEAG) for Part C is a comprehensive tool that looks beyond simple assurances and asks "how do you assure...?" The ability of the State Lead Agency to successfully respond to the questions in this tool rests substantially upon each of the local lead agencies; consequently, this tool should be completed by each local entity in order to identify if the state as a whole can be considered compliant.

Implications of These Requirements

Figure 5 illustrates the federal requirements for the state's Part C system. These components are not unique to Part C; in fact, they are components of all early care and early childhood systems. These components come together to form a highly visible and easily accessible system that can ensure the identification and provision of quality services to families and eligible children; a system that is accountable to consumers and one that does demonstrate that it is a good steward of the public trust. These components provide a tremendous opportunity for collaboration and coordination across different early childhood and social service programs, as they are shared universally and many of the children and families are served by more than one entity. The specificity of terminology may vary while the intent and outcome do not.

State Part C systems often collaborate with other entities on one or more of these components, utilizing existing structures to ensure the Part C components. Some examples include collaborative training systems, multiple-client service coordination structures, data collection and reporting systems, monitoring/supervision or complaint resolution entities. These partnerships vary depending upon the State Lead Agency and are an inherent part of the "system" under Congressional intent.

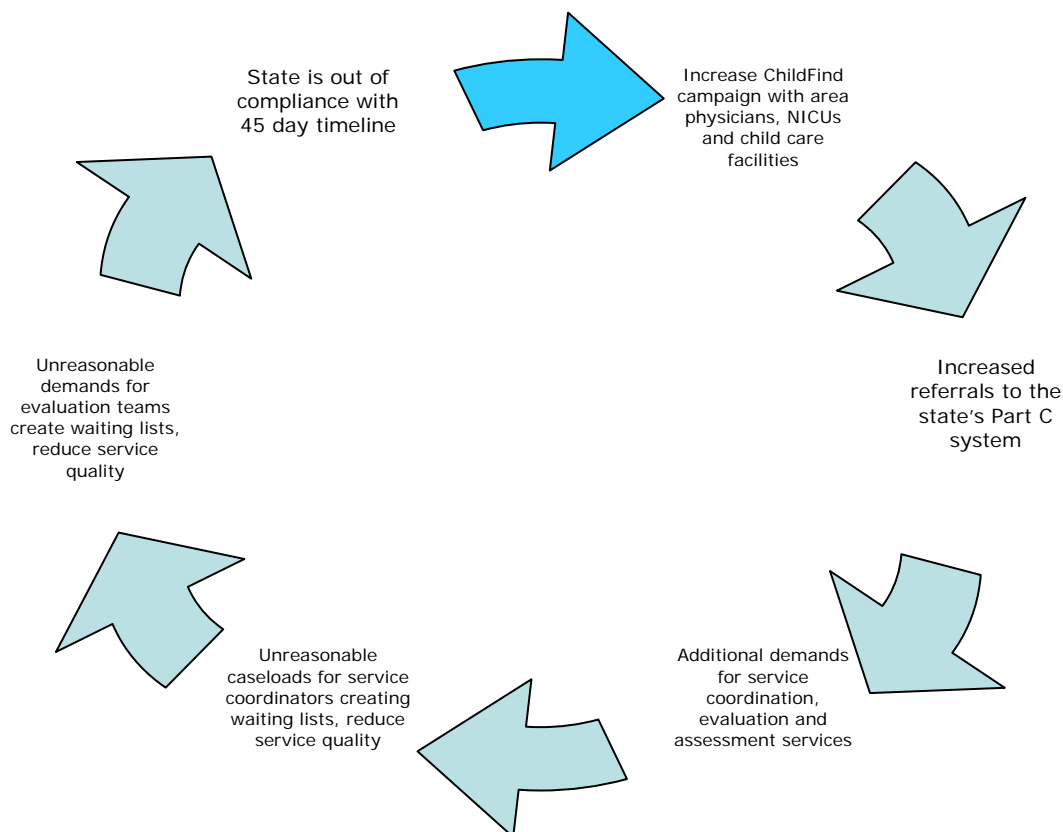
Figure 5: Part C System Components



It is literally impossible to alter one component of a Part C system, including financing, without affecting other components.

For example, understanding the potential prevalence for enrollment facilitates financial forecasting, and assists the state to plan related system components such as provider recruitment, training and credentialing with a particular focus on selected geographic areas or specialty areas. Efforts to incentivize Child Find are important; the incorporation of the prevalence data into an allocation formula will greatly assist to encourage measured and planned growth while moving more closely to the Federal requirement to “locate and identify all eligible children.”

Because of the interrelatedness of the Part C system components, considerable effort needs to be directed to think about the “domino effect” of any change in financing to the system as a whole, and to assist the State in prioritizing their efforts. The “domino effect” is displayed in this diagram, focusing on what is likely to happen in a state which increases its Child Find efforts.



A Sustainable Part C Finance System

Sustainability has a variety of definitions depending upon the “culture” within which we are referencing. Family members, providers, administrators at the state and local levels, and communities want to ensure and be assured that public systems of services and support are accountable and transparent in their operations. In creating and maintaining a sustainable Part C Finance System, it is essential that the three (3) components are incorporated:

- **Social responsibility:** To ensure that the Part C system is responsive to individual child and family needs with high quality and individually defined and provided early intervention services, supporting families in their communities and promoting each child’s development emphasizing their typical routines and daily activities.
- **Environmental Parity:** To ensure that infant and early childhood services are available to all children and families across the age, geographic, income and disability spectrum, and which are carefully coordinated to avoid duplication.
- **Economic Vitality:** To ensure that children are identified as early as possible so that the impact of their developmental delay or disability is ameliorated or significantly reduced, and that a variety of public and private resources are coordinated to be responsive to their needs and result in short- and long-term benefits and savings for society in general.

In addition to being a responsive service delivery system to families and children, a Part C System of Payments uses all available resources appropriately and is publicly held accountable through each of the system components identified in Figure 5. Effective monitoring and supervision is apparent in a rigorous data collection and reporting system. Responsive systems of professional development help to ensure quality services, and effective complaint management systems stand ready when problems arise.

Sustainability suggests that the loss of one funding source would not substantially negatively affect the operations of the Part C system. State Part C systems with

significant reliance on a few funding sources are inconsistent with the Congressional statutory intent related to Part C system funding,

A sustainable Part C system is one where the state and local systems operate in concert, identifying and responding to systemic and local needs in coordination with one another. State lead agencies provide the public assurances for consistency and standardization in the statewide system through the development, implementation and effective policies and procedures, followed up with comprehensive system compliance monitoring. Part C system funding arrangements are largely cultivated at the state level because of the state-wideness of the multiple resources available to support this system.

Through these policies and procedures, the State Lead Agency reduces if not eliminates any barriers to ensuring that there is an adequate capacity of providers who participate in the Part C system at the local level which is sufficient to meet the needs of identified children and families. The State Lead Agency is required to have procedures that ensure services are provided to infants and toddlers with disabilities and their families under this part in a timely manner pending the resolution of any disputes among public agencies or service providers.

Local lead agencies are the “face” of the Part C system to the provider and family communities. They are responsible for ensuring timely access to services and for making sure that the coordinated, interagency system “works” properly for individual children and families according to the policies and procedures established at the state level. While a local lead agency may develop its own policies and procedures, there is considerable vulnerability in this approach as there is no assurance for “statewideness” as required by Federal regulations.

Part C providers are responsible for managing their services in synchrony with the state policies and procedures, and for alerting the local lead agency when problems occur – including barriers in provider participation, funding or service delivery.

For families, a sustainable Part C system is accessible and responsive in a timely manner, regardless of a family's resources, their child's needs or the other eligibilities of their child.

Choice as a Part C Principle

There are at least four (4) levels of choice in a state's Part C system, all of which are important considerations in its routine and daily operations. At its highest level, each state – through its Governor - chooses to participate, accept rules and compliance requirements of Part C. As Governors change, so can the state's decision to participate in Part C.

Choice applies equally to the Local lead Agency (LLA), who chooses to participate, accepts rules and compliance requirements in the assignment as LLA responsible for many of the federal compliance requirements (i.e., local monitoring, fiscal assurances, family rights, opportunities and responsibilities, etc.). Following Part C Federal finance and program requirements, the LLA identifies what it wants to purchase by establishing a method to recruit and engage providers. This may be an open contract opportunity to any qualified provider, or a "Request for Proposals" (RFP) or "Request for Quotes" (RFQ) process that specifies the requirements and obligations to which interested providers respond. This process may be competitive. Most contracts not only detail the LLA's requirements, but also reciprocal expectations such as the requirement of providers to refer children, birth to age three, to the public Part C system within two calendar days, the obligation to accept all available resources, documentation and teaming requirements, etc.

Some states have designated providers that are not part of a RFP or RFQ process; these arrangements are vulnerable due to the "choice of provider" requirement inherent in Federal Medicaid regulations and most private insurance plans.

Providers typically elect to be Part C providers and may choose to be a provider of evaluation/assessments services, to provide one or more EI services, or perhaps elect to focus on a specialty population. There is no requirement generally that force a provider

into the Part C system. With the exception of a few states with centralized financing arrangements, providers are typically recruited at the LLA level. This makes it even more crucial that the State Lead Agency establish standardized, statewide policies and procedures so that the state avoids multiple, confusing if not contradictory rules, practices and expectations of the provider community. This can result not only in capacity problems, but expands the potential for compliance problems.

Families choose to participate in Part C, and they choose the degree to which they participate by accepting all or some of the services identified as needed. This decision to participate or not is a “cognitive,” informed decision, ensuring that the family understands the implications of their decision to participate in the public system. Regardless of their decision or level of participation, the Part C door is always open – based upon the changing needs, situation and decisions of the family.

When overall enrollment is low, or there are families who are receiving services “outside” of the Part C System, it should direct the State Lead Agency to a comprehensive review of all system components as it is highly likely that there are multiple contributing factors to the failure of families to participate.

An additional component of choice relates to family choice of provider, which is a Federal Medicaid requirement and typically also a private insurance requirement. For Medicaid or private insurance covered services, the Part C system must make sure that the unique rules and regulations governing these resources are implemented for families and children enrolled in Part C. This is a non-negotiable requirement unless the manner in which Medicaid coverage is configured specifically removes “choice” as a requirement.

With respect to Medicaid (unless managed through a waiver which is not applicable in Washington State), provider choice means the individual recognized by the Medicaid agency as meeting the provider qualifications – not the agency employing or contracting with the individual. Typically it is the individual who is recognized and licensed or credentialed, not the agency. Provider choice was one key principle

recently reaffirmed in a Maine class action suit⁷ filed on behalf of a number of children, ages 0-5.

Many state Part C systems have collaborated with their Medicaid agency to create mutually agreeable provider qualifications that often reflect additional Part C criteria such as pediatric training, family centered practices, etc.

Some Part C systems report that there are problems with some providers who serve the child and family “outside” the Part C system, and when the insurance coverage is depleted, the provider or family will refer to early intervention in order to seek a new payment source. While all providers, in general, are required through the Part C regulations to refer potentially eligible children to the public system, it is difficult if not impossible for state lead agencies to effectively monitor for and correct barriers to early referral.

Provider choice can actually be a recruitment tool for Part C systems. When families select a provider “outside” the public system, they must have a contract with the LLA in order to receive public funds.

Extending provider choice to all Part C funds is something that several states have done. In practice, this means that the policies and procedures are the same for all children and families, regardless of their funding source. This facilitates training and the subsequent monitoring to ensure consistency statewide. In philosophy, it does make a statement that family choice is a value of the state’s Part C system and that families should be informed consumers and actively participate in the management and evaluation all of the resources which come together to support them and their child.

Further revisions to the KCDDD provider contract should be considered that require providers to refer all potentially eligible children to the public system. OSEP guidance

⁷ United States District Court of Maine, K. S., on behalf of her minor child, T. S., and all other similarly situated individuals vs. Brenda Harvey, Commissioner of the Maine Department of Health and Human Services (June 23, 2007)

with respect to referrals has been that the family, if they choose to decline to participate in the public Part C system, must do so directly with the public system or LLA (or their designee). As families bring new providers to the Part C system, the opportunity for contract development may be substantial initially. And, through the contract monitoring process, if a provider doesn't comply with all sections of the contract - the LLA must take appropriate steps.

Observations, Findings and General Comments

Earlier in this Report, the Consultants provided a discussion and display of the multiple resources that can compose a Part C system's financial foundation and discussed the importance of statewide Policies and Procedures governing all facets of a state's early intervention system. In Washington State, the following are substantial issues identified by the Consultants:

- The Consultants heard from a number of local providers and administrators that the utilization of the State Plan in lieu of comprehensive, statewide system Policies and Procedures is a barrier to the effective administration of the KCDDD Local Lead Agency and its contracted providers.
- Many of the funding inequities are caused by state-level regulations but contribute substantially to an imbalance in financing at the local level.
- These funding inequities result in variations in practice related to eligibility determination, IFSP development and service delivery approaches particularly related to the Federal requirement that services be delivered in the "natural environment."
- The lack of consistency in collection of family cost participation with respect to insurance co-pays and deductibles, as described in ITEIP guidelines, is extremely problematic for King County, where a higher percentage of families in early intervention have private insurance that is used for their IFSP service(s).
- Data, while a substantial effort, is not available to be used as an integral part of most programmatic or financial management of King County's early interventions system nor is there confidence in the integrity of the data that exists in the ITEIP DMS.

- During interviews with providers, the consultants confirmed that some providers are non compliant with Part C requirements particularly with respect to center-based services. In spite of this, King County DDD continues to contract with these providers. This gives mixed messages to the general provider community and does not reinforce good practice.

Stakeholder input obtained early in the process verified these issues. Consequently there are findings and recommendations contained in this Report that focus primarily on the local level; we have also included state level recommendations for those issues that cannot be corrected at the county level.

Part C System Financing

While ITEIP utilizes a variety of resources to support Part C, these resources are not generally available to all Part C providers and, when accessed, are distributed in varying methods (unit reimbursement vs. capitated rate). This patchwork of funding streams, configuration and lack of tracking leaves the King County Part C System vulnerable with respect to ensuring that Part C is the payor of last resort – that other public or private sources pay for commitments for which they are legally responsible.

There are considerable improvements in fund acquisition and management that are possible at the state and local level including the opportunity for enhanced partnerships with local infant and preschool programs and services where money does not have to “change hands” in order for services to be coordinated and provided across multiple providers.

This section addresses some of these fund source issues directly.

School Funding

Currently, funding for early intervention is provided by most, but not all, Local Educational Agencies (LEAs). In King County, some of these funds are received by the Local Lead Agency while other school funds are contracted directly with providers. Not all Part C providers receive these funds, as a result of state statutory language that allows school districts to contract with whomever they want. Further, there are differences in direct and indirect cost charges which result in varying per child amounts. If a local provider sub-contracts with another provider, there is a further dilution of the amount of reimbursement that arrives at the child-service level.

In addition to varying reimbursement amounts in general, there is currently no LEA reimbursement for child services from May through August. This problem will only compound by fall 2009 when all LEAs are required to participate in supporting early intervention.

There is tremendous resistance by many of the King County providers (primarily those who currently “hold” LEA contracts directly) for these LEA funds to be all directed to the LLA for receipt and distribution, which would help to achieve greater equity and parity for the County. However, this arrangement would help to unify the LEA reimbursement, decrease administrative costs, increase efficiencies and permit a wider distribution of these funds for all children in the County who are served through Part C, extending to all approved providers.

Medicaid

Medicaid issues exist at two distinct levels. First, not all Part C providers are Medicaid providers, meaning that they don’t bill for covered services and other fund sources are used instead.

Secondly, Washington State is foregoing significant Medicaid reimbursement opportunities that exist in other states (i.e., developmental therapy (special instruction), service coordination, augmented reimbursement for covered services provided in natural environments). This is substantial considering that there is no Medicaid reimbursement for service coordination, and the level of special instruction provided is considerably more than the average seen in other states where comparable studies have been performed by the Consultants.

Private Insurance

Private insurance is another resource which is not consistently utilized by all King County Part C providers for covered services. While this is problematic (as with Medicaid billing and reimbursement), the greater issue is that family co-pays and deductibles are sometimes “scholarshipped” by a local provider without a common, standardized way to assess “inability to pay.” This practice results in an equity issue when some families are billed and pay, and others aren’t. This practice, further subjects the State and Local Lead Agencies to due process complaints from families and the potential for findings and potential recovery when resource utilization and compliance with individual regulations are audited.

In recognition of the current methods for utilizing private insurance in Washington State, the State Lead Agency must develop statewide policies and procedures related to a “system of payments” that provides a common pathway for determining family “inability to pay” when insurance is accessed, and what local, state or federal funds will be used in lieu of family payment of co-pays (and deductibles, if so determined). This is state-level policy and not something that KCDDD can resolve on its own and an issue that leaves the entire State vulnerable.

Children with Special Health Care Needs Program (CSHCN)

The Department of Health (DOH) does not directly fund the implementation of IFSP services, but Health districts do offer limited services throughout the state to which some families have access. As part of their federal maintenance of effort, the DOH is a source of funding for Neurodevelopmental Centers (NDC) and the CSHCN. This funding benefits some agencies providing services in King County and reimburses for some services not otherwise reimbursed for other agencies or children. Reimbursement is also higher for these NDCs than for agencies or children not served through the NDCs.

In other states, CSHCN is a source of specialty assessments, care management for children with complex medical conditions, and as critical partner in the continuum of care for children with disabilities or developmental delay past age three. Because of the narrow focus of services offered through IDEA, Part B special education, CSHCN is often an important partner in ensuring continuous medical care management and access to services not considered as educationally relevant. As such, the actual transition and data reporting for children prior to age three should include multiple partners – not just Education.

Center based Services (“Natural Environments” Requirement)

Part C is a unique system of services and supports which are intended to promote the competency of family members and other caregivers in the promotion of developmental skills for the enrolled child, as well as promoting community supports and services which maximize each family’s daily routines and activities.

Natural environments are not just a location for services but offer many opportunities for children with disabilities or developmental delays to participate in the same activities and routines as do similarly aged children without disabilities and learn new skills and abilities. In setting-based services, professionals go to an environment such as a child's home or child care center and provide the same type of services as would be provided in a specialized location such as an early intervention center, special school, hospital, or clinical setting. In other words, professionals are likely to provide child-focused interventions by creating specially-designed activities that address specific developmental goals and then doing those activities within a child's home or other setting that is part of the child's daily routine⁸.

There should also be discussion through the IFSP process of where, according to the family's plans and priorities, the child would "typically" be – such as in a child care facility, should the parent's plan be to return to work. This is particularly pertinent to the Part C system obligations, since it is this system that should be the resource to the community in the support and individualization of existing community settings to better meet the diverse needs of children with disabilities.

It is in this manner, through the IFSP team planning and implementation, that the Part C system helps to support families at home, in their community and for inclusion through participation in a variety of services, supports and settings that families with typically developing children enjoy. Because of the combination of the multiple eligibilities of Part C-enrolled children and the diversity in family life and values, participation in these settings is often what would have typically occurred for the child and is not an artificial or fabricated experience.

The multiple resource base of the Part C system naturally promotes inclusion for families and children through the identification and utilization of the child's eligibilities in concert with their needs, and emphasizes the Part C system as a resource to the vast array of settings that are typical for infants and toddlers in their individualized consultation, training and collateral services for dually served children and families. The more broad

⁸ McBride & Peterson, 1997

a state's resource base is for Part C signals a system which offers a variety of services and supports to families and children, constantly emphasizing the role of family and community in the child's daily routines and activities and cultivating their skills through individualized consultation and support.

The Federal regulations under Part C speak to the requirement of services in the natural environment, with the compliance standard established at 100%. In some, limited instances, Federal regulations permit services in other settings but require a time-specific plan detailing the strategies to be used to identify and relocate services to the "natural setting." KCDDD is currently contracting with providers who are very committed to their center based programs and paying them for these services without individualized justification, etc. Reimbursement recommendations made by the Consultants attempt to modify the current practice and help to move Part C services to more home and community based settings and discourage the relatively automatic placement of children in these center-based programs.

Recommendations

The Consultants' recommendations appear in a sequential order that is essential for successful implementation. It is not uncommon in evaluation work that stakeholders presume that garnering additional financial resources is the single, right answer to improving a state's Part C system. In fact, it is essential to first examine and improve the service delivery system in order to first use the current resources available effectively and responsibly, and secondly, to expand current resources or attract new ones. Related to this examination is the review of system components for efficiencies and effectiveness. These recommendations provide integration of both the system components and service delivery system in a holistic approach to overall systems improvement.

The Part C System Contractual Process

The contract between KCDDD and the area provider community is a significant lynchpin to the operations of the Part C ITEIP system locally, and to ensure compliance with a variety of Federal regulations including EDGAR. The Consultants have made

considerable recommendations for revisions to the current KCDDD contracting documents. In addition to those recommendations, we wish to add the following new recommendation relevant to the contracting process.

Recommendation 2.1:

In addition to the contract improvements suggested earlier by the Consultants, it is further recommended that additional improvements be developed that would reflect the EDGAR requirements in detail specific enough to guide contracting programs to successfully comply with these obligations. Further revisions to the KCDDD provider contract should be considered that require providers to refer all potentially eligible children to the public system. OSEP guidance with respect to referrals has been that the family, if they choose to decline to participate in the public Part C system, must do so directly with the public system or LLA (or their designee).

The Part C System Service Pathway

Outcome: The Service Pathway is an incredibly important product which informs a variety of related initiatives, including but not limited to documentation, training, procedural safeguards and funding. It describes, in brief sequential steps, what happens from referral to transition from the Part C system. An example of one service pathway is provided on the next page.

Finding: The attempts to create a Service Pathway during the course of this contract didn't include the broad-based of stakeholders, and was more problem-focused than creative. These efforts did highlight the considerable disparity of stakeholders when it comes to agreeing on sequential steps and functional definitions which are consistent with Federal regulations, particularly with respect to evaluation and assessment services.

Recommendation 2.2:

This Service Pathway could serve as a discussion tool for a small group of varied stakeholders, focusing first (Pathway #1) on "what is" the ITEIP King County Service

Pathway and secondly (Pathway #2), what improvements would be made to increase efficiencies, regulatory compliance and effectiveness.

Recommendation 2.3:

Utilizing the Service Pathway #1 to contrast and compare system documentation to functional steps. Identify where documentation links to data entry, and where improvements in both related practices would be achieved to support Service Pathway #2. This step will identify documentation improvements or additions, perhaps duplications, which exist. Documentation must link with data entry to include sequence, terminology and format.

Recommendation 2.4:

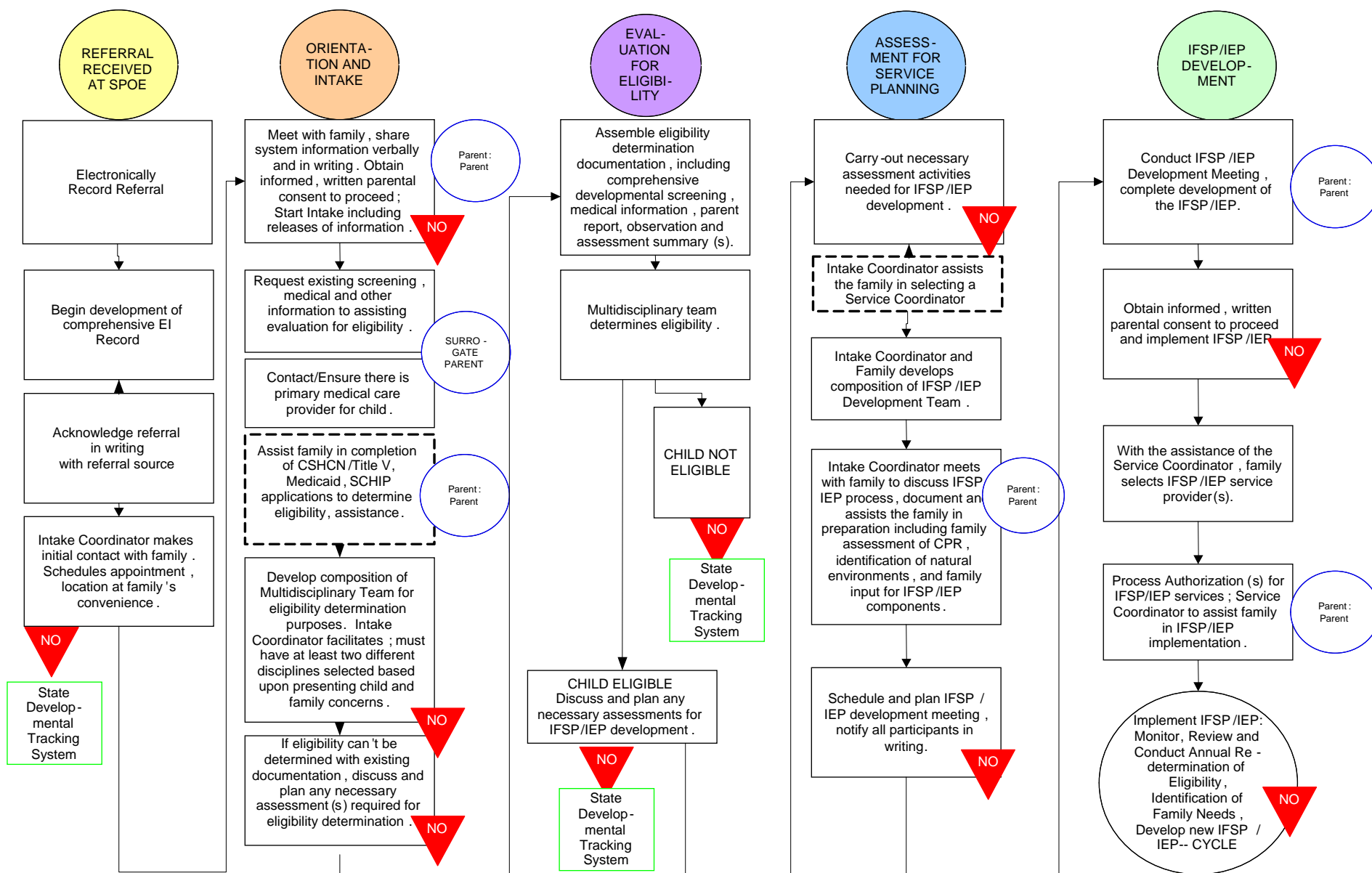
Require that all referrals are made to KCDDD, which will help to ensure family choice of provider, comprehensive data collection and monitoring of referrals, timelines and eligibility determination services. Currently referrals go to specific providers who manage the intake, eligibility and IFSP process – informing the County “after the fact” of eligibility determination, needs and services. This system leaves the Local Lead Agency vulnerable should the timelines fall short, errors in eligibility determination are made, etc. Modifications to the flow of referrals will help to standardize the response to all referrals in King County.

This recommendation would establish KCDDD, or their designee who is not a provider of direct service, as the System Point of Entry for receipt of all referrals, from which a mechanism would be developed to ensure timely referrals for evaluation for eligibility and assessment for service planning, and for service coordination.

Recommendation 2.5:

The performance of a timely evaluation for eligibility and, if eligible, assessment for service planning should be realigned to reflect the Federal definitions of these terms. Currently considerable time and money is expended by “testing” children at referral to determine if they are eligible, rather than relying upon existing documentation, parent intake and medical information, and the option for informed clinical opinion.

- Through the RFP or RFQ process, it would be possible to solicit specific providers who wish to focus substantial effort on the evaluation and assessment component of ITEIP. The Local Lead Agency may also want to consider the cultivation of Part C Evaluation Teams which would be cross-agency, multidisciplinary teams that may be dedicated to the sole performance of these activities for all newly referred children.



Recommendation 2.6:

Maximize the current resources available by:

- Requiring that all contracted providers enroll and bill for covered services to Medicaid and private insurance.
- Develop county-wide policies and procedures which reaffirm the State's expressed practices related to the utilization of private insurance and the billing and collection of related family cost (e.g., co-payments and deductibles).

Recommendation 2.7:

- Payments for services on behalf of children participating in child care or community-based preschool would be limited to that portion of time that is specific to the child's IFSP needs and different from what everyone else in the setting is receiving.
- Elimination of payment for center-based services that are not part of the child's daily routines and activities unless there is a full justification in the IFSP that includes a short-term goal (no longer than six months) for moving service to daily routines and activities.

Recommendation 2.8:

Cultivate, as a county, together with other stakeholders a variety of options and opportunities for family members to participate in which provide peer support, group opportunities and resources related to disability services, community services, transition supports, etc.

Recommendation 2.9:

Create a funding hierarchy that expressly represents the current resources available in Washington State and King County specifically. Utilize a stakeholder process to identify potential new resources and determine if these partnerships would link to the Part C system components or to the service delivery system, vis a vis the Service Pathway.

Section 3: Streamline current Payment, Billing and Fiscal Reporting

Background

KCDDD, the Local Lead Agency for early intervention in that county, essentially pays for services utilizing a capitated monthly reimbursement according to the table below. Multiple billing processes are used to access funds and providers are required to report on days of service by child. Some of the weaknesses with the current process are as follows:

- a. Inability to establish payor of last resort for federal funds⁹;
- b. Inability to ensure Medicaid, private insurance are “payment in full;”
- c. Funds don’t match the services (intensity) provided;
- d. Inability to fully account for the full cost of the King County system;
- e. Inability to track funds back to a specific service and child;
- f. Currently IFSPs typically do not identify fund source; initially the IFSP lists all potential sources and no one goes back to identify which fund source ultimately paid for the service or if there was a blend of funds responsible.

Table 2: Current Reimbursement System

FUND SOURCE	MONTHLY REIMBURSEMENT	INVOICE PACKET
State DDD Child Development King County	\$194 per child per month served between January 1, 2008 and June 30, 2008 and \$196 per child per month between July 1, 2008 and December 31, 2008.	County Human Resource Information System (CHRIS) form and invoice
State DDD Child Development Snohomish County	Fee for service according to Snohomish County fee schedule and reimbursement guidelines.	CHRIS form and invoice
Public Schools	\$481.25 per child per month, except June, July, August and September when no reimbursement will be made.	Client list form and invoice
IDEA Part C	\$110 per child per month served or actual cost of services, whichever is less. Child must have a completed IFSP which has been signed by the family.	Client list form and invoice
IDEA Part C Extraordinary Expenses	Case by case basis with prior approval by the County.	Extraordinary Expense Billing Invoice

⁹ Past State Audits found the existing process to be adequate, but as the school district and other funds have been accessed more successfully verification of POLR has become problematic.

Allocation Methods

Processes or methods of funding services rendered or equipment may be established using several different approaches including: a) fee for service, b) a per capita basis, c) an allocation basis, d) a cost reporting basis or e) a resource based relative value system (RBRVS). Each presents a different opportunity that should be explored by examining respective issues and challenges in Table 2. Issues are not stated as either a strength or weakness; that determination can only be made after viewing the desired outcome or the related systemic context. For example, the issue that a fee for service system provides little financial risk for persons delivering service is a “strength” for a system with provider shortages and a “weakness” in a system with fund shortages.

The goal when selecting a particular strategy is to closely align financial incentives with desirable outcomes related to the provision of early intervention services. The reality of many Early Intervention Systems is that the reimbursement strategy is a combination of any number of the following approaches. Often, the interwoven nature of the reimbursement strategies is not considered in the initial design and often goes unquantified.

Table 3 displays five (5) approaches to reimbursement and provide a definition, options, issues and data needed.

Table 3: Fund Distribution Methods		
1. Fee for Service	Definition	A method of charging whereby the practitioner bills for each encounter or service rendered. Fee for service differs from other payment options in that it does not change with the number of services actually used or if none are used.
	Options	<ul style="list-style-type: none"> • Event based- the payment is the same regardless of time spent and includes a descriptor of the event. This is sometimes used for evaluation assessment types of activity. • Unit based- includes a definition of time that is considered billable activity. • Service or Discipline based- relationship between personnel types and service definitions must be clear
	Issues	<ul style="list-style-type: none"> • Encourages patterns of care that expand service. Good quality service planning is a must in this type of system. • There is no financial incentive to use the highest levels of qualified staff. Non-fiduciary personnel reward systems should complement this system. • Provides little financial risk for persons delivering service. • Without expenditure history, this system may be the most challenging for administrative management. Management of the planned levels of service on the Individualized Family Service Plan (IFSP) or Individualized Education Program (IEP) is helpful to estimate the financial commitment. • Is supportive of an open vendor based system. • Common definition of a "unit?"
	Data Needed	<ul style="list-style-type: none"> • The cost per direct service hour. • The cost per hour for support services and administration. • The actual amount of billable time vs. non-billable time.
2. Capitated	Definition	A reimbursement system whereby the rate is proportional to the number of individuals in a population.
	Options	<ul style="list-style-type: none"> • Child basis means a single monetary award amount based on serving the child. • Modifiers for service levels that exceed a normal range.

Table 3: Fund Distribution Methods		
	Issues	<ul style="list-style-type: none"> • Available and accurate historical data is needed to create an average reimbursement. • This system generally encourages a lowering of the standard deviation of the mean levels of service and should be supported by a good service planning process and should review the level of actual delivered service. • There is a disincentive to work with children and families requiring high service levels. The system should be supported by a process requiring all families to be equally selected. • The more efficient and effective the service provider is the less the financial risk. • Works most effectively in a system where a single provider holds the responsibility for service. Distributing payment beyond a single provider could be difficult. • Financial management is challenged when enrollment is on the rise.
	Data Needs	<ul style="list-style-type: none"> • Average total cost per child. • Variability and/or standard deviation of average cost. • Actual services planned/provided.
3. Cost Report	Definition	User defined reporting system that may include information such as agency characteristics, utilization data, cost and charges by an early intervention cost center, and financial statement data. Medicaid often uses the cost reporting option for hospital and nursing home services.
	Options	Definition of Cost
	Issues	<ul style="list-style-type: none"> • This system is usually an “after the fact” process that requires a method of payment prior to completing the cost report and subsequent settlement process. • Cost reporting can be complex. • Cost reporting requires clear and concise definitions. • Without expenditure history, this system may be the most challenging for administrative management. • Offers no or little financial risk for providers. • Is supportive of an “open vendor-based” system. • May provide the best routine source of on-going cost information with clear definitions.
	Data Needs	<ul style="list-style-type: none"> • Provider cost information
4. Formula Allocation	Definition	To apportion resources to a specific purpose based on factors that are deemed to create equity.
	Options	Criteria Selection

Table 3: Fund Distribution Methods		
	Issues	<ul style="list-style-type: none"> Defining the allocation methodology so that the result is an equitable distribution of resources is always challenging. The method of distributing other funds should be considered as part of the allocation methods. For example, if another funding source is paying for a particular service or for a special population of people, then the formula should consider that impact. This system generally encourages a lowering of the standard deviation of the mean levels of service and should be supported by a good service planning process and should review the level of actual delivered service. May be the easiest to financially manage at the administrative level.
	Data Needs	<ul style="list-style-type: none"> Data as defined in the allocation methodology.
5. Resource Based Relative Value	Definition	Creates a base reimbursement rate and adds a relative value index to what might be called “practice expense” and work or time and intensity. This concept initially came from the Omnibus Budget Reconciliation Act (OBRA 85) and is a method commonly used within Medicare and Medicaid.
	Options	<p>The index may include:</p> <ul style="list-style-type: none"> Geography Discipline Service Location Service Method
	Issues	<ul style="list-style-type: none"> This is a relatively untried approach within the field of early intervention. This system requires identification of a base upon which to build the index. Defining this base could be challenging. Without expenditure history, this system may be the most challenging for administrative management. Management of the planned levels of service on the Individualized Family Service is helpful to estimate the financial commitment. Is supportive of an “open vendor-based” system.
	Data Needs	<ul style="list-style-type: none"> The cost per direct service hour for the base item. The cost per hour for support services and administration. The actual amount of billable time. Differences from the base to the index.

Recommendations

The fund distribution methodology should remain as a capitated per child amount, but must include recognition of all sources that come together to fund services. Currently there is no way to track payments to individual services, thereby assuring that the variety of conditions and requirements of specific fund sources (e.g., “payment in full” for Medicaid and private insurance) can be met. A detailed budget and rate calculation methodology is provided as Appendix C to this Report.

Recommendation 3.1:

It is essential to conduct a comprehensive Cost Study in order to establish a capitated per child reimbursement rate. In the interim, information collected from some sources within King County was coupled with cost study information obtained from other States to create a possible structure, as follows, for consideration for KCDDD reimbursement.

Recommendation 3.2:

Reimbursement Structure:

- Home and Community-based Services would receive a monthly capitated amount of \$800/child
- Center-based monthly amount assumes a 3:1 ratio and is reduced by 30% to create a financial incentive for refocusing services to the home and community settings; recommended at \$200/child per month.
- Children receiving services in both settings will be paid at a composite rate of 50% that of center based and 33% that of the home and community rate, for a monthly capitated amount of \$450/child per month. Capitation may look different for specialty providers

Recommendation 3.3:

The overall reimbursement structure must reflect the importance of paying for what the Local Lead Agency values. We strongly encourage consideration of targeted funding for some of the infrastructure components, such as Child Find, data entry, interagency collaboration, etc.

Recommendation 3.4:

Implement a process whereby providers, on a monthly basis, report all earned third party revenue (in detail) from other Part C sources such as insurance, Medicaid and School District funds with the exception of school districts that contract solely with KCDDD. The Local Lead Agency will deduct 90% of this revenue from the monthly provider payment based upon their billing.

- o This recommendation provides 10% of earned third party income to the provider organization as an incentive to cover administrative costs.
- o This process ensures that there is parity and equity in provider reimbursement across all funding sources.

Recommendation 3.5:

Current reporting would change from reporting days of service to hours of service by service type.

Recommendation 3.6:

Utilization Management – ITEIP data isn't available at LLA to do utilization management. This requires KCDDD to have their own 2nd set of data in order to monitor for compliance/compensatory services, vis-à-vis, the IFSP planned services vs. delivered.

Section 4: Recommendations for State Level Consideration

As indicated earlier in this document, it is unusual for the Consultants to work at the local lead agency level. Some of the issues that KCDDD is dealing with can only find relief at the state level. Before beginning the examination of the King County fiscal system, the Consultants engaged in a conversation with representatives of the Washington State Lead Agency.

The Lead Agency offered full support of the evaluation activities and provided data and information as it was requested. As the evaluation process continued, there were ongoing conversations with Lead Agency staff regarding the findings as well as the identification of issues that were outside of KCDDD's control. The State Lead Agency provided insight and documentation regarding a number of issues that were identified.

The recommendations below emerged as a result of the Consultants' work in King County and the recognition that some of the barriers to effective and efficient services are systemic in nature, and are the responsibility of the ITEIP and not the KCDDD.

Policies and Procedures (P&P)

Strong and consistent guidance is essential from ITEIP which defines all facets of the early intervention practice expectations. This guidance is commonly seen in the articulation of a System Policy and Procedures Manual (P&P) which is used as a foundation document for training development, technical assistance and monitoring/supervision.

The ITEIP recognizes the State Application to the Office of Special Education Programs (OSEP) as containing the policies and procedures by which local lead agencies as well as providers must practice. During provider and staff interviews, as well as during Task Force meetings, the Consultants repeatedly heard that the guidance within the State Plan did not contain sufficient specificity to ensure consistent practice and appropriate guidance. While OSEP has always approved the State Plan as submitted by ITEIP, providers would like more detailed information to guide the implementation of the State Plan requirements.

The absence of a formally written P&P manual to provide for standardized practices statewide results in not only the lack of consistent practices, but also in the provision of substantive training which affects practice and results in significant fiscal variations across the localities. In King County, this is reflected in different practices related to accessing 3rd party resources including co-pays and deductibles which leave the individual provider entities and Local Lead Agency vulnerable for audit findings and potential recoupment.

Recommendation 4.1:

- 1) Long-term: The State Lead Agency should consider the development of a statewide Policies & Procedures manual which reflects the Federal Part C

Regulations and works towards conforming with the OSEP Fiscal Monitoring requirements

- 2) Short-term: On an interim basis, KCDDD should develop local Policies & Procedures which reflect the Federal Part C Regulations and the Washington State Plan and work towards conforming to the OSEP Fiscal Monitoring requirements. Because of the number of agencies in King County that cross county lines in the delivery of service to eligible children, the KCDDD lead agency should consider the possibility of multiple counties jointly doing this so that providers would experience increased consistency throughout their practices regardless of which county they are working or contracting with.
 - a) Since this area of the state serves the majority of eligible children, this activity would serve to stabilize and bring consistency to practices that would benefit the children and families that are served. Once the manual has been developed, there will need to be substantive training to support its implementation.
 - b) As the local lead agencies fulfill their monitoring and supervision requirements, the evaluation of compliance with the established policies and procedures must be incorporated.

Potential Legislative Improvements: Public School Funding

Public school funding constitutes the largest single financial resource to the ITEIP system statewide, and will have the potential to be universal by September 2009 when all localities are required to participate. The way in which these funds are constructed, however, do not work well for the Part C system as a whole in that numbers of children do not benefit from these resources if they happen to enter the ITEIP system between May and August when typically these funds don't "flow" to the localities or providers. Additionally, the current practice of some school districts refusal to contract with all Local Lead Agency approved early intervention providers creates an inequity for access to public school funds. In order to equalize the access and utilization of school funding for all eligible children, the following recommendation is made at the state level.

Recommendation 4.2:

Establish a consistent amount of funding for each child that is available for 12 months of the year and reflects a standardized administrative cost for the LEA. These funds should be available to every LLA recognized early intervention provider. The result of this regulatory change would mean that funds would be more consistent with the continuous, annual enrollment of children and would include all children referred throughout the year.

Potential Legislative Improvements: Insurance Legislation

Washington State has traditionally incorporated the use of private insurance as one of the fund sources utilized statewide in the funding of Part C services. In discussions with the Consultants, state staff indicated their commitment to continue the use of this resource. State staff indicated that they have been very clear with Local Lead Agencies that all families with private insurance must be required to utilize this resource and must pay co-pays and deductibles.

As the Consultants conducted the evaluation of the use of private insurance in King County, the consistency across provider agencies of implementing this requirement was significant. Some agencies are consistently billing families and collecting the co-pays and deductibles. Other agencies are utilizing private resources to waive the requirement for families regarding the co-pays and deductibles. This is creating an inconsistent and inequitable system for families. The required use of private insurance also creates a potential impact for families whose children have significant medical issues and the use of their private insurance could have an impact on the lifetime cap. There are a number of states that have already passed state legislation related to private insurance. The NECTAC website contains information which includes the statutory language from these states.

<http://www.nectac.org/topics/finance/statelegis.asp>

Recommendation 4.3:

- Long Term: Work with the Washington Legislature to develop private insurance legislation to recognize Part C services as covered services that:

- Exempts co-pays, deductibles and life time benefit caps
 - Establishes an annual per child amount which includes all Part C services and is billed quarterly
 - Increases annually based upon annual inflation factor/COLA
- Short Term: Through the contractual and monitoring process, ensure that all provider agencies are implementing this state requirement consistently.

Family Cost Participation

While Washington State doesn't have family fees per se, the utilization of private insurance and the manner in which co-pays and deductibles are treated requires the statewide standardization of family cost participation to ensure proper and timely reporting of FCP – including collections and use of funds and make sure families know their rights, opportunities and responsibilities related to Part C participation.

Federal regulations require that the evaluation for eligibility and assessment services are to be provided at public cost. This citation is found in at least two places in the current regulations. §303.321 Comprehensive child find system, where d.(1) references evaluation and assessment. Child Find must be provided at no cost to the family which would include use of their private insurance or any related family co-pays, deductibles, etc. Further, §303.521 Fees specifically excludes evaluation and assessment services from family cost participation:

(b) Functions not subject to fees. The following are required functions that must be carried out at public expense by a State, and for which no fees may be charged to parents:

(1) Implementing the child find requirements in Sec. 303.321.

(2) Evaluation and assessment, as included in Sec. 303.322, and including the functions related to evaluation and assessment in Sec. 303.12.

The qualifier above, "at public expense," appears to exclude the use of private insurance even if the state Part C system were absorbing the family co-pay, deductible.

ITEIP guidelines do not support consistency with Federal “inability to pay” requirements because of reported disparity in the manner in which co-pays/deductibles are managed, both of which are a cost to the family. The Consultants acknowledge that there are states that do use private insurance as a payment vehicle for evaluation and assessment services. It is the general opinion of the Consultants that these states are in jeopardy and based upon our read of the regulations, feel that the most prudent advice for clients client is to avoid use of family resources for these services without specific written guidance from OSEP.

Recommendation 4.4:

The Consultants recommend that Washington State revisit the use of private insurance to fund evaluation and assessment services, and that a “system of payments” is developed to reflect the interface between “inability to pay” and family cost related to co-pays and deductibles. The policies stated in the state plan and the guidelines that have been distributed to the Local Lead Agencies appear to have inconsistencies. A review of both documents to ensure consistency is recommended. The Consultants also recommend that it would be valuable within the context of this recommendation to discuss family fees, particularly related to family denial to access private insurance.

Once the state has settled on these issues in terms of practice, the Consultants further recommend that statewide policies and procedures are developed and supported by training, which ensure that all providers are following consistent practices when utilizing private insurance and the payment of family co-pays and deductibles.

El Medicaid Initiative

There are currently multiple ways in which Medicaid is accessed to support Part C services which contributed to the lack of provider payment parity and overall equity and accessibility to Part C services for individual children who are dually enrolled in Part C and Medicaid. These reimbursement variations hinge more on the provider type than any other variable.

Washington State is not accessing Medicaid for all Part C services, resulting in the use of Federal funds, CDS funds or other locally generated revenue for what in other states are Medicaid covered and reimbursed services.

The Consultants have included as Appendix D, a technical guidance paper describing one approach to creating a singular access to Medicaid for all Part C services at a reimbursement rate which supports the Part C system requirements. This EI Medicaid Initiative would establish an EI Services Chapter in EPSDT which would include all Part C service reimbursement related to the functions of:

- Screening
- Multidisciplinary Team Services
 - Evaluation for Eligibility
 - Assessment for Service Planning
 - Team Meetings
- EI Services
- Service Coordination

Section 5: Implementation Considerations

It is important to emphasize that the implementation of these recommendations, excluding those directed to the State Lead Agency, are largely focused on the service delivery side of the Part C system and only a small portion of the recommendations deal directly with finance issues.

We recommend the continuation of the participatory, stakeholder process in working through these recommendations and in the evaluation of the change process to include required mid-stream corrections as needed.

The summary of recommendations appears below, in a sequential order that the Consultants believe builds upon linked change initiatives and helps to ensure the integrity and success of the system improvements.

- KCDDD should complete the recommended changes in the contracting document

including inclusion of EDGAR and the provider obligation for timely referrals in addition to the comprehensive list of improvements earlier provided.

- Review and develop a mutually acceptable Service Pathway for King County

Examine the King County service delivery pathway against the federal regulations and clarify, most particularly, evaluation for eligibility and assessment for service planning requirements.

- Establish a System Point of Entry structure for King County to receive and distribute referrals in a timely and responsive manner.
 - KCDDD is extremely vulnerable under the current way that referrals flow in King County. The majority of referrals are currently directed to the provider entity who then determines if they will serve the child, or perhaps refer the child elsewhere if they are not the appropriate provider. This flow doesn't assure that KCDDD:
 - Is informed of each referral made to the ITEIP system locally,
 - Is assured that all needs are properly identified and responded to. and
 - Is assured that families, where required, are given choice of provider. Provider choice is not a Part C Federal requirement; extending "choice" to these funds is a state-level policy decision. Choice would apply when public and private insurance is used, according to the individual requirements of these resources.
- The KCDDD should develop a Part C ITEIP Policy & Procedures Manual that expands the Service Pathway discussion into discrete actions that are consistent with federal regulations and state policy, integrates the process with documentation, and provides "best practice" concepts and ideas for providers.
- The KCDDD should develop an RFP/RFQ process that clearly identifies what early intervention services the Local Lead Agency is willing to purchase, how the services are to be delivered to include Part C requirements including documentation, third party billing, provider qualifications, etc.

- This RFP/RFQ process would also be important to use when seeking specialized services that are not otherwise available, or not sufficient in volume to meet the need.
 - It would also be used, depending upon the decisions made through the Service Pathway discussion, to recruit evaluation teams, independent service coordination, etc.
- The KCDDD should retain a percentage of Part C funding to support children with special service requirements that would fall outside of the average service expectation.
- The KCDDD should retain an additional percentage of Part C funding to support training and technical assistance to ensure quality service provision consistent with your policies and procedures.
- Data collection and use of data should be integral to all daily management of the King County Part C system.
 - Recommend use of the Pierce County data system with development of an integrated billing component.
- IFSP data, to include specific services, frequency and intensity, and funding source must be current.
 - Data must be entered routinely as funding source information is confirmed, and whenever services are changes from the existing IFSP (added, increased, decreased or terminated).
 - An example of this would be for the child who is Medicaid-enrolled, PT, SPL and OT would be reimbursed by Medicaid while SI would be CDS or other local funds.
 - Another example would be when private insurance is used for a period of time (e.g., 10 treatments) and then CDS funds are used. This level of detail is essential to ensure proper tracking and monitoring.
- In addition to the suggestions already made for contract language changes, the contract language should be strengthened to include:
 - Requirement to bill Medicaid for all enrolled children who receive Medicaid reimbursable services ;

- Requirement to bill private insurance for all children with third party coverage who receive third party reimbursable services;
 - Requirement to bill and collect families for co-pays and deductibles;
 - Requirement to maintain documentation of billing; and
 - Requirement to appeal denials.
 - Elimination of payment for segregated center based services.
- The KCDDD should require the development of a Part C budget by every provider agency that includes anticipated third party revenue(s) including but not limited to School District funds, CDS, Medicaid and private insurance reimbursements, private fund raising initiatives, private insurance co-pay and deductible payments made by families, etc.
- The KCDDD should establish a capitated per child reimbursement that reflects the different costs of:
 - Center-based services;
 - Specialty services; and
 - Full range of community-based services.
 - Payments for services on behalf of children participating in child care or community-based preschool would be limited to that portion of time that is specific to the child's IFSP needs and different from what everyone else in the setting is receiving.
 - Elimination of payment for center-based services that are not part of the child's daily routines and activities unless there is a full justification in the IFSP that includes a short-term goal (no longer than six months) for moving service to daily routines and activities.
- For each billing cycle, The Local Lead Agency should reduce the total payments to providers by 90% of collected revenue from other Part C sources such as insurance, Medicaid and School District funds.
 - The Local Lead Agency should change the current billing documentation from daily attendance reporting to encounter based reporting (minutes/hours), by service type.

Appendix A: Provider Agency Questions

- 1) How many Part C children do you serve on an annual basis?
- 2) What percentage of children are Medicaid eligible?
- 3) What percentage of children have private insurance?
- 4) What methods do you use to manage fiscal resources?
 - a) How do you know what resources are being used on an individual child basis?
 - b) How do you make that decision?
- 5) Do you track delivered service detail by practitioner at the event level?
- 6) Do you have any data about travel time/mileage?
- 7) Are you billing using the 837 P HIPAA compliant (EDI) format? Is it paper (CMS 1500)?
- 8) Can you estimate how much time practitioners spend:
 - a) In direct service with children and families?
 - b) On behalf of children rather than direct service?
- 9) How much administrative time is spent in data entry for the state's EI system?
- 10) How is service detail entered into the data system?
- 11) Do you have issues with staff turnover?
- 12) How do the wages you pay for direct service providers compare to the market rate?
- 13) Of the total claims that are submitted to Medicaid, what percentage is paid?
- 14) Of the total claims that are submitted to private insurance companies, what percentage is paid?
- 15) Do you collect co-pays and deductibles from families?

Appendix B: State Insurance Legislation

Several states have enacted legislation relating to the use of private insurance for Part C services.

- **Massachusetts** mandates that both indemnity and managed care plans cover \$5,200 in early intervention services per year per child and an aggregate benefit of \$15,600 over the total enrollment period.

[Provisions Respecting Domestic Companies](#)

[Non-Profit Hospital Service Corporations](#)

[Medical Service Corporations](#)

[Health Maintenance Organizations](#)

- **Connecticut** requires coverage of Part C services up to \$3,200 annually and exempts these costs from counting against any lifetime caps in a family's policy.
- **Virginia** also requires coverage of Part C services up to \$5,000 annually and exempts these costs from counting against any lifetime caps in a family's policy. The state also applies these provisions in a separate act to the insurance program for state employees.
- **New Hampshire** requires coverage for Children's Early Intervention Therapy Services up to \$3,200 per child per year not to exceed \$9,600 by the child's third birthday.
- **New Mexico** requires coverage for children, from birth through three years of age, for or under the family, infant, toddler program administered by the department of health, provided eligibility criteria are met, for a maximum benefit \$3,500 annually for medically necessary early intervention services. The services are provided as part of an individualized family service plan and delivered by certified and licensed personnel working in early intervention programs that are approved by the department of health. No payment shall be applied against any maximum lifetime or annual limits specified in the policy, health benefits plan or contract.
- **New York** requires insurers to reimburse early intervention services if they are otherwise covered under a policy and exempts these payments from counting against any lifetime caps.

- [Indiana](#) also requires insurers to reimburse early intervention services if they are otherwise covered under a policy and exempts these payments from counting against any lifetime caps
- [Rhode Island](#) requires coverage of Part C services up to \$5,000 annually per dependent child and exempts these costs from counting against any lifetime cap in a family's policy.

[HMO's](#)

[Accident and Sickness Insurance Policies](#)

[Non-Profit Medical Service Corporations](#)

[Non-Profit Hospital Service Corporations](#)

Source: <http://www.nectac.org/topics/finance/statelegis.asp>

Appendix C: Rate Model

King County Rate Modeling with Budget Impact

The rate modeling spreadsheet, found at the end of the Appendix section, is used to develop proposed reimbursement rates and to compute the budget impact for KCDDD. The method employed for this modeling is similar to that used when conducting a full cost study and combines some KCDDD specific information with information gleaned from studies completed by SOLUTIONS Consulting Group, LLC in other states. One key recommendation of importance to KCDDD within this report is that a full cost study be completed since very little KCDDD data could be used for the modeling due to serious data integrity issues.

Since so little data could be confirmed, it is imperative that methods be put in place to measure and track actual data against budget assumptions. Some data could be tracked periodically, while items like child service months should be systematically counted with the budget continually updated and monitored.

Personnel Costs

The average hourly direct service personnel cost was taken from salary data specific to Seattle (10/2008) using a web site called Salary Wizard. A composite hourly amount was created, in section B, using relevant practitioner types for King County. The composite hourly wage used in the rate modeling is \$31.00 per hour or \$64,480 per year exclusive of benefit cost.

King County DDD			
A: Salary.Com Data Review for 10/2008 : Seattle Washington			
Practitioner	25th Percentile	75th Percentile	Average
Child Life Specialist	\$43,800	\$53,159	\$48,480
Occupational Therapist	\$66,435	\$80,930	\$73,683
Occupational Therapist-Home care	\$68,610	\$79,668	\$74,139
Physical Therapist	\$71,075	\$82,449	\$76,762
Physical Therapist - Home care	\$74,435	\$85,574	\$80,005
Speech Language Pathologist	\$61,897	\$75,963	\$68,930
Speech Language Pathologist - Home Care	\$67,632	\$84,441	\$76,037
Social Worker (MSW)	\$51,172	\$60,690	\$55,931
Registered Nurse	\$61,396	\$73,958	\$67,677
Public School Teacher	\$48,005	\$64,157	\$56,081
COTA	\$43,046	\$51,560	\$47,303
PTA	\$41,916	\$51,392	\$46,654
Case Worker (Home Care)	\$44,483	\$51,886	\$48,185
Average All Types	\$57,223	\$68,910	\$63,067

Salary.com is a trademark and service mark of Salary.com, Inc. Salary Wizard is a trademark of Salary.com, Inc.

<http://aolsvc.salary.aol.com/careersandwork/salary/>

B: Hourly Salary Amounts (Composite)			
Practitioner	25th Percentile	75th Percentile	Average
Child Life Specialist	\$21.06	\$25.56	\$23.31
Occupational Therapist-Home care	\$32.99	\$38.30	\$35.64
Physical Therapist - Home care	\$35.79	\$41.14	\$38.46
Speech Language Pathologist - Home Care	\$32.52	\$40.60	\$36.56
Social Worker (MSW)	\$24.60	\$29.18	\$26.89
Public School Teacher	\$23.08	\$30.84	\$26.96
Average of Selected Types	\$27.51	\$33.13	\$31.30

Benefits are computed using 27.6% of Hourly Salary. The KCDDD Financial Reporting for the first six (6) months of calendar 2008 shows this percentage at 18.4% (\$976,771/\$5,317,887).

Information from the Salary Wizard site suggests a higher percentage at about 28%, inclusive of some time off which we account for in a later section of this modeling. Benefits are computed as $\$31 \times 27.6\% = \8.56 .

Administrative and Support

This category includes all costs, other than direct service personnel cost, that are necessary for the person to "get the job done." This category, for example, includes supervision, insurance, postage, travel, etc. The table to the right shows this relationship for other states where a Cost Study has been conducted. There is somewhat of a relationship between higher hourly wages and a lower cost of admin and support. For example, NJ and CT have the highest hourly cost and the lowest comparative percentages at 28% and 26.5% respectively. Absent detailed information specific to King County, the Consultants used 25% as the cost for administrative and support, with 75%

Ratio of Admin/Support to Direct Service Personnel Comparisons			
State	Direct Service Costs as a Percentage of Total Costs	Support & Admin Costs as a percentage of Total Costs	Average hourly personnel costs
Tennessee	66.3%	33.7%	\$18.43
Connecticut	73.5%	26.5%	\$27.29
New Mexico	66.4%	33.6%	\$19.67
Virginia	66.3%	33.7%	\$27.16
Louisiana	67.8%	32.2%	\$24.89
New Jersey	72.0%	28.0%	\$30.29

assumed to be the cost of direct service personnel. Total Hourly Cost is computed as $\$39.56 / .75 = \52.74 . Admin and support costs are the difference between the total and the Hourly Personnel Costs or $\$52.74 - \$39.56 = \$13.19$. This totals \$27,435 per direct service person in administrative and support costs.

1. Event/Occasion % of Time (Face To Face)

- Only a portion of a direct service practitioner's time is spent in face to face activity with children and families. Some time is administrative in nature (such as, sick and vacation days or staff meetings); other time is spent driving to the location of the

child. Even more time can be accounted for in preparation, documentation or training. The percentage of time each direct service person spends in face-to-face activity is important in understanding the cost of a direct service hour. Dividing the total hourly cost by this percentage allows us to compute the total cost per face-to-face hour, sometimes referred to as a direct service hour. Given early intervention time studies in other states, this percentage has ranged from 33% to as high as 42% when exclusively counting Home and Community based services. The Consultants used 40% for King County DDD. The cost per direct service hour is computed as $\$52.74 / .40 = \131.85 .

- b. The Consultants thoroughly reviewed KCDDD data in an effort to compute average an average quantity of child service hours per month and were not able to reach a conclusive number. As a conservative estimate, the Consultants used 5.85 hours of actual delivered services per month per child.
- c. Since services in King County are not exclusively Home and Community based, multiple rates were established and a blended rate was used for budget modeling purposes. A qualitative and quantitative review was undertaken and subsequent discussion with KCDDD staff helped to create the utilization estimates for each of the rate items. A blended rate of \$520.21 represents 10% at the center based rate, 33% at the Home and Community based rate and 57% with a mixed service delivery of both types.

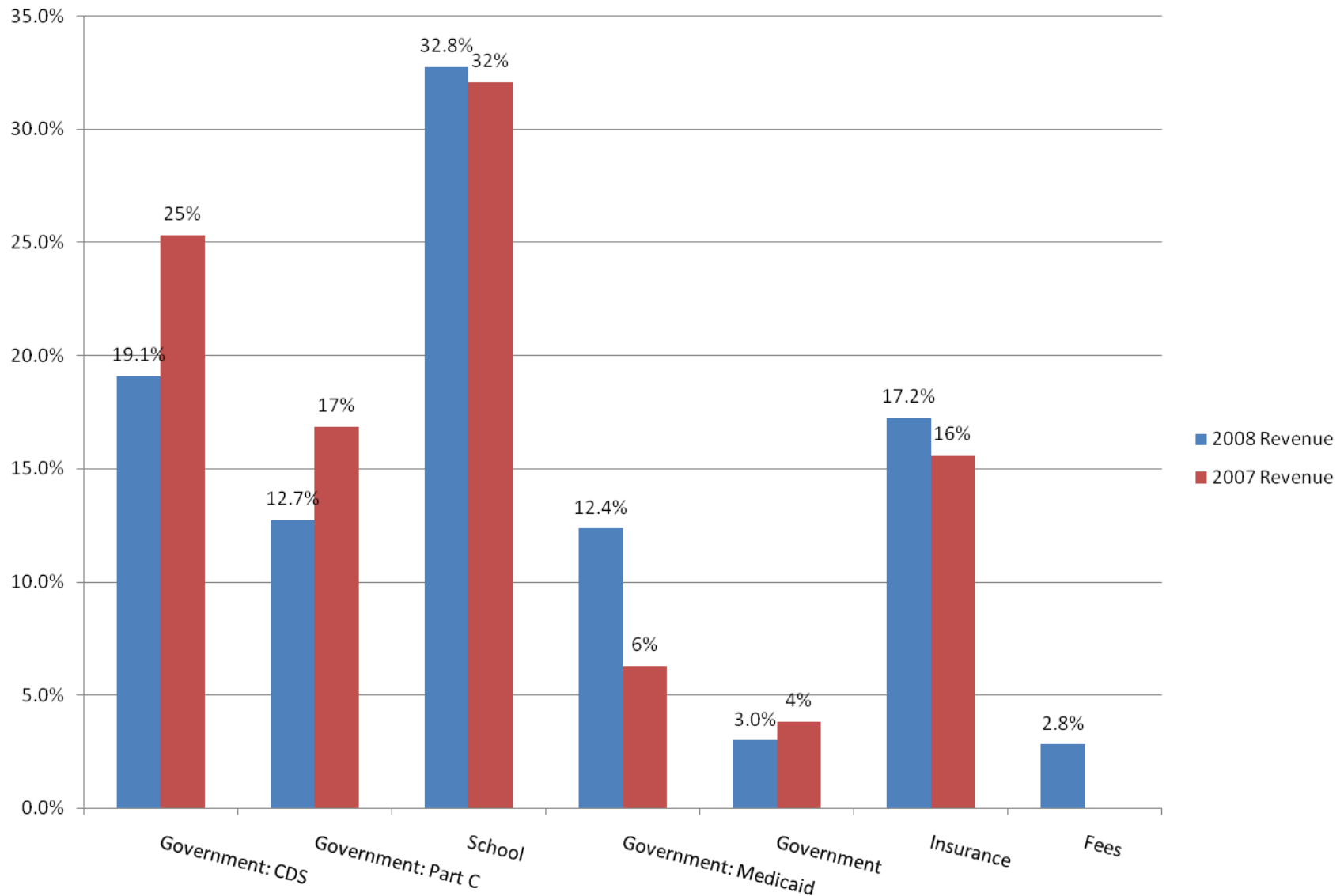
2. Number of Child Months

- a. The number of child months could not be definitively computed because of differences in the method of counting. The current payment system counts children in both entry and exit months. The new rates should be used as payment for a complete month of service. Given that definition, it does mean that services should be paid either in the entry or exit month for a child and not both. KCDDD should provide a payment rule and track child service months routinely.
- b. For budget purposes, the Consultants and State team agreed that 15,000 child months should represent a change in their counting method and should allow for some growth, if current counts are accurate. This is an important number when paying on a capitated monthly basis.

- c. The total estimated cost of the King County DDD system is \$7,803,080. Revenue, in addition to that which passes through KCDDD, must be accounted for through the billing process. Revenue estimates based on the first six months of calendar 2008 show the King County DDD funding as 40% of the total (19.1%+12.7%+8.9%=40.7%). When adjusting the amount to allow local program retention of 10% of the total dollars they collect, the King Count obligation is estimated at 47% of the total or an annual requirement of \$3,667,450. Comparisons between 2007 and 2008 shown on the next page present similar results.

Revenue (2 Quarters: 1/1/2008-6/30/2008)		
Type	Sum	% of Total
Government: CDS	\$1,354,133.71	19.1%
Government: Part C	\$903,208.96	12.7%
School KC	\$631,174.14	8.9%
School	\$1,693,156.33	23.9%
Government: Medicaid	\$876,238.14	12.4%
Government	\$212,591.83	3.0%
Insurance	\$1,223,450.75	17.2%
Fees	\$198,962.00	2.8%
	\$7,092,915.86	100.0%

KCDDDDRevenue Comparison



Rate Modeling: King County				
	Description	-5%	Average	+5%
1	Personnel Costs			
	Personnel Hourly Salary Amount	\$29.45	\$31.00	\$32.55
	Benefit % of Hourly Salary	26.2%	27.6%	29.0%
	Benefit Cost Per Hour	\$7.72	\$8.56	\$9.43
	Total Personnel Cost	\$37.17	\$39.56	\$41.98
2	Admin & Support Cost			
	Direct Service Ratio to Admin	78.8%	75.0%	71%
	Hourly Admin & Support Cost	\$10.03	\$13.19	\$16.94
	Total Hourly Costs	\$47.20	\$52.74	\$58.92
3	Event/Occasion % of Time	38%	40%	42%
	Cost per Direct Service Hour	\$124.22	\$131.85	\$140.29
	Monthly Hours	5.56	5.85	6.14
	Monthly Cost (Assuming Home & Community Based)	\$690.35	\$771.32	\$861.73
	Blended rate	\$494.20	\$520.21	\$546.22
4	Number of Child Months	14,250	15,000	15,750
	Total Estimated Annual Service Costs	\$7,042,280	\$7,803,080	\$8,602,900
	King County Estimated Responsibility %	45%	47%	49%
	King County Estimated Responsibility \$	\$3,144,380	\$3,667,450	\$4,245,530
Blended Monthly Rate				\$520.21
Center-based services;		Assume 3:1 and 70% of cost	\$179.98	10%
Full range of community-based services			\$771.32	33%
Mixed service Delivery		Assumes Center Based plus 1/3 of home and community based services	\$434.51	57%

Appendix D: Medicaid

Purpose of this Paper

The purpose of this Paper is to provide a recommendation for configuring Medicaid reimbursement to support the State of Washington's 0-3 ITEIP System.

A variety of options were evaluated by the *Solutions* Consultants although we anticipate that the leadership of the State will have much more information with which to make a determination given the changing landscape of Medicaid, the state's economy and other perhaps competing or complementary initiatives. In making this recommendation, we considered the Notices of Proposed Rule Making (NPRMs) issued by the Centers for Medicare and Medicaid Services (CMS) specifically related to Targeted Case Management (TCM) Services, Administrative Claiming and the CMS clarification of rehabilitation vs. habilitation services.

Why The Emphasis On Medicaid?

There is no argument that the early intervention services required by Part C of the IDEA are within the scope of covered services provided under the Medicaid program. Medicaid covers direct medical services included in an IFSP under the following conditions:

- The direct medical services are medically necessary and included in a Medicaid covered category (speech therapy, physical therapy, etc.);
- Compliance with all other Federal and State Medicaid regulations. This includes regulations related to provider qualifications, comparability of services, provider choice and the amount, duration and scope provisions; and
- The direct medical services are included in the State's approved Medicaid plan and/or available under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program.

Accessing Medicaid: A Variety of Approaches Are Utilized

States utilize a variety of avenues to access Medicaid for early identification and the provision of services and supports for very young children and their families. These include:

- Outreach/Enrollment Partnership that recognize the system's ability to collect documentation to support enrollment into Medicaid
- Early Periodic Screening, Diagnosis and Treatment (EPSDT)
- Targeted Case Management (TCM)
- Medicaid State Plan services, particularly physical, occupational and speech/language therapies

- Development of a State Plan Amendment for uncovered services, such as developmental Promotion/developmental therapy, social work services, family therapy, etc.
- Waivers including 1915(c) Home and Community Based Waivers targeted to specific population(s) and/or service(s). The intent of waiver services is to reduce the frequency of institutionalism, promote self-determination and to permit states to provide targeted programs for individuals based on need which often reflects services not otherwise available under Medicaid to the general population.
- Katie Beckett/TEFRA (Tax Equity and Financial Responsibility Act of 1988) permits states to enroll children with disabilities who live at home and need extensive care but who would not otherwise qualify for Medicaid due to their family income and resources.
- Managed Care Initiatives
- Medicaid Administrative Claiming (MAC) to include system activities at the State and local levels required to assure the delivery of quality services to children and families
- Title V and State Rehabilitation Agency Interagency Agreements represent the unique Federal requirement for State Medicaid agencies to partner with “sister” State agencies in the planning and delivery of services to targeted populations, such as children with special health care needs (CSHCN), pregnant women, low birth-weight babies, children with sensory losses, etc.

The Deficit Reduction Act (DRA) established a variety of State-directed options designed to change the way that Medicaid is constructed, and gives considerable State latitude and decision-making ability to constructing alternative ways of “doing business.” Long-term care, or supports for individuals with disabilities, accounts for 37% of all Medicaid dollars nationally.

The importance of de-institutionalism, personal freedom and independence are hallmarks of the DRA – anticipated to refocus Medicaid to a person-centered and consumer-controller program. For families with young children with disabilities, these opportunities are the most significant as they couple with the requirement that the provisions of EPSDT – Early, Periodic Screening, Diagnosis and Treatment – which remains as a requirement for the <21 population.

These DRA changes are largely being distributed through guidance documents in the form of SMDs¹⁰ at this point in time with emerging “draft” regulations as time goes on. The concepts presented in this Paper are built upon an extensive review of the literature available on the DRA, various interpretations on the implications for the target population, and a creative approach to ensuring comprehensive, coordinated care for the State’s most vulnerable children. There are several options to consider as one reconfigures Medicaid for any population. Key considerations from a public policy perspective include:

- Ease of management at State, local and provider levels, particularly in terms of accessibility, documentation and monitoring/surveillance;
- Cost projections – figuring out the potential impact (people and funding) for State consideration;
- Continuity of care for individuals as they “age” from one public system to another, or when eligibility changes and service needs continue; and
- Adequate capacity or availability of appropriately qualified providers.

As of this date, several NPRMs have been issued; three of these directly affect services to children eligible and enrolled through the Individuals with Disabilities Education Act (IDEA). These are:

- Administrative Claiming for School Districts
- Targeted Case Management
- Rehabilitation Services

Each of these affect services for children ages 0-3 enrolled in Part C in the following ways:

- Administrative Claiming
 - The regulatory changes say that Federal Financial Participation (FFP) is not available when the fundamental purpose of the program is not the provision of Medicaid services.

¹⁰ State Medicaid Director Communications

- This principle is applied to FFP for administrative services of a program, commonly called “administrative claiming.” Several state agencies across most state governments have administrative agreements with the Office of Medical Services for a variety of populations/programs, allowing them to administer Medicaid services within their program area. FFP would no longer be available for their administrative costs.
 - No reimbursement will be permitted for the administrative activities performed by public school employees, which includes (but is not limited to) those activities related to locating and linking eligible children to Medicaid, assisting in directing the follow-up to diagnostic and treatment services, interagency work that helps to prevent against duplication and ensure coordinated, comprehensive services to children eligible for a variety of public programs (primarily due to poverty), etc.
 - Additionally, reimbursement is eliminated for children’s transportation to and from school. Children may still be transported from school or home to services under Medicaid reimbursement if these are covered services.
 - No FFP may be claimed for activities performed which are performed specifically for the purposes of the program and not for Medicaid. Noted program activities in the NPRM include ChildFind, the development and management of an IFSP or IEP, and the administration of IDEA procedural safeguards to a family/child.
- Targeted Case Management Services
 - Eliminates the opportunity for a child to have two (2) case managers funded under Medicaid, even if there is no duplication in terms of the tasks which either person is performing for the individual.
 - This has often been used by states to provide, for example, a case manager for child welfare related needs and a case manager who is focused only on the IFSP or IEP services that a child would be receiving.
 - The only acceptable billing for case management services is “fee for service.” Acceptable units of service are defined in 15 minute units.
 - Transporting clients to appointments and accompanying them to appointments is no longer an eligible activity.
 - “Blended” models of case management (a.k.a. service coordination) will not be reimbursed by Medicaid. For example, an early intervention (EI) practitioner who functions as a “service coordinator” within the EI

program is not be eligible if he/she also provides another EI service under the Individual Education Plan (IEP).

- o States are permitted up to two (2) years to implement the majority of the changes required above; this timeline varies by state. The regulations were to go into place March 3, 2008 but have been deferred to June 2008, with the potential for a further moratorium now being considered by Congress. However many states have moved quickly to reorganize their case management systems to meet the single case manager requirement and/or to bill in 15 minute increments.

– Rehabilitation Services

- o Clarifies and defines the difference between “habilitation” and “rehabilitation” services, noting that habilitation may not be a covered service under rehabilitation, and that these services more appropriately fit under EPSDT.¹¹
 - This especially applies to children aged 0-3 because the majority of services provided to these children represent “Developmental Promotion” to help the child achieve skills that they, for one reason or another, have not accomplished.
 - CMS has recommended and worked with several states to move these services to EPSDT which really protects it significantly and permits frequency, intensity, etc., to be based upon the individual needs of the child as well as including currently uncovered but eligible services if the EPSDT screen requires this.
- o Introduces in §441.45 the concept of “intrinsic” effect, meaning that CMS will not cover services which are provided through a “non-medical program” which would include child welfare, juvenile justice or educational programs.

We have yet to experience the full impact of all of the Medicaid revisions as set forth in the Deficit Reduction Act (DRA). The collective language in the regulations suggests further tightening of the regulations, particularly as it pertains to other Federal programs which may have common clients. While Congress approved legislation that created a moratorium to April 2009 on the majority of these proposed NPRMs, it is only reasonable for states to make alternative plans and implement creative strategies to maintain critical Medicaid reimbursement in their 0-3 systems.

¹¹ EPSDT: Early Periodic Screening, Diagnosis and Treatment

The current national economic condition will force hard examination of all publicly funded programs and services; the degree to which Medicaid supports state Part C systems is often tremendous. Currently Medicaid constitutes <15% of the total revenue in the Part C system in King County yet some providers interviewed reported that as much as 70% of the enrolled Part C children are also enrolled in Medicaid. While there is a range of service-types, it seems fair to speculate that a majority of the services provided to enrolled children are special instruction, family counseling and training which are not covered Medicaid services in Washington State. This would explain a significant part of the discrepancy between enrollment data and Medicaid reimbursement within the total KCDDD Part C system.

Washington State Medicaid Coverage for Children

In Washington State, there are several Medicaid eligibility categories including some innovative options for non-resident population. The following information was gleaned from interviews with some King County providers, the King County administrators and the State's Part C Coordinator. There was no contact or conversation directly with the State's Medicaid agency within the context of this evaluation.

Early Periodic Screening, Diagnosis and Treatment (EPSDT) is a program providing EPSDT to persons under 21 years of age who are eligible for Medicaid or the Children's Health Program. In conformance with 1905(r) of the Act, all medically necessary diagnosis and treatment services are provided regardless of whether the service is included in the plan. Limitations do not apply other than based on medical necessity. Washington State Medicaid eligibility for children is at 200% Federal Poverty Level (FPL).

School-based healthcare services (SBHS) provided to a child with a disability in accordance with the Individuals with Disabilities Education Act (IDEA):

- Address the physical and/or mental disabilities of the child;
- Are prescribed or can be recommended by a physician or another licensed healthcare practitioner within his or her scope of practice under State law; and
- Are included in the child's IEP in accordance with IDEA.

All Medicaid beneficiaries have freedom of choice of providers¹². The state and school districts may encourage, but may not require, Medicaid eligible children to receive necessary healthcare services in the school setting from school-based providers. If a

¹² With the exception of waivers, where issues related to state comparability, choice, etc. may be waived.

specific provider is required by the public school, it is this Consultant's understanding that Medicaid SCHS should not be billed for the IEP service because this violates the family choice requirement.

Medicaid reimbursement through "Traditional" Medicaid chapters is also available to other practitioners including, but not limited to, psychologists, respiratory therapists, certified pediatric/family nurse practitioners, advanced registered nurse practitioners, dental hygienists, denturists, chiropractors (for EPSDT only), dietitians, nutritionists, occupational therapists, pharmacists, physical therapists, podiatrists, radiological technicians, speech/language pathologists, audiologists, licensed non-nurse midwives, birthing centers, and registered nurses first assistants. Medical Nutrition Therapy is a face-to-face interaction between a licensed/certified dietitian and the client and/or client's guardian for the purpose of evaluating and making recommendations regarding the client's nutritional status. The service must be medically necessary and the client must be 20 years of age or younger with an EPSDT referral. These practitioners are limited to services within their scope of practice.

The current Administration under Governor Christine Gregoire's initiative to cover all children in the state with health insurance by 2010 is being achieved by expanding the SCHIP¹³ eligibility standards to three times the Federal Poverty Level in January 1, 2009. At that point, parents in families with incomes above that ceiling will be able to buy coverage for their children by paying Medicaid's full cost of coverage. The new coverage, which will be consistent with Medicaid's traditional major medical coverage, includes medical, dental and vision benefits. The new eligibility rule is under SCHIP and applies to all children ages 18 and under who live in Washington State and whose families meet the income criteria. Families with incomes more than two times the Federal Poverty Level will pay a modest monthly premium for the coverage. The premiums are \$15 per child per month, with a maximum of \$45 a month per family. Families in this SCHIP program have a choice between enrolling in a managed care organization or in the fee for service program.

This SCHIP initiative essentially means that all children in Washington State have access to health care, either through traditional employment or purchase options or through Medicaid. Providers interviewed speculated that as many as 70% of enrolled Part C children were Medicaid covered. The income comparison between Medicaid and SCHIP is illustrated in the following table.

¹³ State Children's Health Insurance Program

Number of People in Family (parents & children)	Medicaid Free Health Insurance (approximate income per month)	SCHIP Low-cost Health Insurance (approximate income per month)
1	Up to \$1,734	\$1,703 to \$2,128
2	Up to \$2,282	\$2,283 to \$2,853
3	Up to \$2,862	\$2,863 to \$3,578
4	Up to \$3,442	\$3,443 to \$4,303
5	Up to \$4,022	\$4,023 to \$5,028
More	Add \$580 for each additional family member	Add \$725 for each additional family member

Home Health Services are covered services in Washington State and is reportedly used as a reimbursement source through Medicaid for some children enrolled in ITEIP. One of the key criteria for services under Home Health is that these individuals must not be able to access their care in the community. Services in the natural environment, emphasizing daily routines and activities, are not synonymous with home health care requirements and use of this vehicle to access Medicaid reimbursement has, in at least one other state, resulted in large recoveries. Part C services provided through “home health” do not technically meet the primary purpose of home health services.

The Title V agreement is utilized in Washington State through the Neuro-Developmental Clinics (NDC) under the auspices of the Department of Health. Some but not all of the Part C providers have this distinction, which permits them to be reimbursed at higher rates for some covered services, and also has an administrative claiming opportunity for these provider organizations.

The Department of Social and Health Services (DSHS) recently updated the payment method, covered services, and provider qualifications for School Medical Services provided to special education students enrolled in Title XIX Medicaid by public schools. DSHS pays school districts using the Resource-Based Relative Value Scale (RBRVS) payment method. Covered services include physical, occupational and speech/language therapies, psychology, audiology, nursing and counseling services. The service categories are broad and varied within this chapter and appear to include all children serviced through the IDEA, through public schools, ages 0-20. It is unclear if children enrolled in Medicaid through the state’s SCHIP initiative are covered under School Medical Services, although these services are covered in general under the Washington SCHIP.

Currently, the Federal share of Medicaid reimbursement for the State is 54.08 cents; the SCHIP Federal share is 67.86 cents. This Federal share is call “FFP” or Federal Financial Participation and is referred to as FFP in the body of this report. The State is required to

generate a “match” with state funds necessary to “draw down” this FFP. Currently, the ITEIP system does not have any state funds allocated expressly to it and consequently does not contribute to any of the “match” obligation of the State for services provided to children 0-3 in ITEIP.

Keys to Contemplating Change

Key to any State reconfiguration of Medicaid is the State’s will to pursue these avenues of opportunity.

States typically have preferred, historical ways of accessing Medicaid – waivers, EPSDT expansions, etc. The DRA challenges us to think “outside of the box” and focus on what is best for the consumer FIRST and then to fashion Medicaid in a manner that best supports their vision and need. There are certainly fiscal concerns related to the DRA including the potential impact of Federal budget cuts for individual State Medicaid programs.

Considering the numerous avenues to accessing Medicaid as presented earlier in this Concept Paper, the following recommendation is presented for consideration for the State’s 0-3 ITEIP System. Considerable collaboration and coordination across and within both the State departments involved in the administration of the IDEA and Medicaid is essential to ensure that any initiative successfully responds to the local needs, is in alignment with the individual IDEA program requirements, and that the initiative can be quantified with respect to utilization and potential revenue, including match requirements as the coming years unfold.

ITEIP leadership may want to investigate the opportunity for plannedful and meaningful expansion of these partnerships with other early childhood programs and services in order to meet the “natural environments” requirements of Part C. This would include infant and early childhood home visiting programs include PAT, Early Head Start, etc., where there is a considerable developmental and family focus already. Many of the infants and toddlers in Part C may be dually eligible for these programs. Partnerships can be cultivated to utilize their providers for Part C developmental services with training and consultation from the Part C system. This kind of collaboration helps to “grow” the Part C provider base, meets the Federal requirements for Payor of Last Resort (POLR), and helps to reduce duplication and prevent fragmented and sometimes confusing care.

In planning system improvements related to financing for early childhood and family supports and services, there are multiple programmatic issues which must be considered. Supports and services to eligible children and families should:

- o be consistent with the method or desired approach(es) to providing services,
- o be cultivated or improved in terms of accessibility and utilization including expansion and supports for a variety and availability of appropriately trained and qualified providers,
- o “match” or conform to the population to be served (e.g., cultural diversity),
- o be compatible with how required data will be collected and verified, and
- o facilitate service monitoring and supervision to ensure timeliness, quality and compliance.

Developmental vs. Therapeutic Service Approach

A significant public policy issue encountered when crafting the Medicaid State Plan Amendment (SPA) focusing on Early Intervention Services is to clearly define the covered services in scope and practice, define the qualified provider(s) and to articulate any service limits or requirements which may be designed to focus practice on “good” or “best” practice and reduce inappropriate levels or frequencies of service. Federal Part C regulations define *Early Intervention Services* as:

“... designed to meet the developmental needs of an infant or toddler with a disability and as requested by the family, the needs of the family to assist appropriately in the infant’s or toddler’s development, as identified by the individualized family service plan team, in any one or more of the following areas, including--

- (i) Physical development;*
- (ii) Cognitive development;*
- (iii) Communication development;*
- (iv) Social or emotional development; or*
- (v) Adaptive development;”*

and include a requirement for each State to establish the highest entry level of qualifications for practitioners for services.

All states have some degree of Medicaid reimbursement opportunity for school based health services; the delineation of medical vs. educational services is very clear as a result of the recent DRA. School-aged special education services are required to ensure that the child can participate in the “regular” curriculum with their age peers. Early intervention is more expansive and generalized to the five (5) developmental domains noted above with a greater focus on generalization of skill and overall daily functionality in a variety of modalities.

Further, a child in the 0-3 Part C system may have service needs which extend beyond the requirements in the IDEA, particularly if these services are more medical or therapeutic than developmental in nature. These services are not part of the IDEA IFSP requirement but are often noted as “other” services on an IFSP so that service coordination and non-duplication can be assured. This step is important in preventing contraindicated care as well.

Services for individual children 0-3 under the IDEA and their families, including type, frequency, intensity and duration, should be articulated without regard to funding source limitations or constraints. Once the approach to service delivery is agreed upon, funding is then identified. This approach avoids letting funding “drive” the service delivery, and means that there are sometimes when program decisions are made which exclude certain resources from the EI funding “quilt.”

Parity in Medicaid Reimbursement across Washington State

Just as not all children in early intervention will be eligible or enrolled in Medicaid, localities will likely not experience 100% success in third party reimbursements, particularly when it involves Medicaid and private insurance. Billing issues arise, problems with having an enrolled provider are encountered and interruptions in child enrollment all combine to reduce anticipated revenue. These realities need to be factored in if making adjustments in an allocation formula based upon anticipated Medicaid revenue. Some of this disruption can be prevented with aggressive Service Coordination efforts.

Because of the varying populations and eligibilities, it is even more critical that KCDDD seriously consider the recommendation made to utilize monthly provider agency reporting and billing for non-third party covered services and credit these providers with their earned revenue. Failure to adjust for varying third party revenues results in disproportionate distribution of Federal and KCDDD resources.

The Role of EPSDT in the IDEA 0-3 Services System

The Omnibus Budget Reconciliation Act of 1989 (OBRA'89) significantly strengthened and clarified Medicaid's existing mandatory EPSDT benefit for children. EPSDT is a separate program under the standard Medicaid program which targets children who are enrolled in Medicaid, ages 0-18 and, in some states, up to age 21. Regardless of "how" a child becomes eligible for Medicaid, all eligible children are entitled to participate in the State's EPSDT program. There can be no difference, once enrolled in EPSDT, in the kinds of service that an individual child receives based upon other Medicaid program eligibility. Under EPSDT, all pre-existing conditions must be fully treated.

Federal law and regulations require states and territories to provide Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services to Medicaid eligible children under the age of 21 as part of their Medicaid program. The purpose of EPSDT is to identify "physical and mental defects" and to provide treatment to "correct or ameliorate any defects or chronic conditions found." States/territories are required by federal Medicaid to inform children and their families of the availability of EPSDT services, their benefits, and where and how to obtain them. They are also to provide transportation and scheduling assistance if requested, to assure that the children receive necessary services. It is important for IDEA planners to understand that families elect whether or not they will have their child participate in EPSDT; each State is required to fully explain the benefits to families of this exceptional program in order to encourage full State participation.

"Screening" means a periodic comprehensive child health assessment which includes regularly scheduled examinations and evaluations of the general physical and mental health, growth, development, and nutritional status of infants, children and youth. These screenings are to include a physical examination, vision and hearing testing, age appropriate immunizations, any necessary diagnostic laboratory tests, and a dental examination beginning at least at age 3. "Diagnosis and Treatment" means further assessment of any condition(s) noted during a screening and the provision of any medically necessary treatment services, irrespective of their inclusion in the State plan as a routinely covered service.

OBRA'89 established the requirement for routine and interperiodic screenings under EPSDT, and required that any federally allowable diagnostic or treatment service identified through a screening would be provided for the child regardless of whether the State includes the service in its Medicaid State plan. Most states use the periodicity schedule as established by the American Academy of Pediatrics to guide their EPSDT services. The screening content was clarified to include the following:

- Comprehensive Health and Developmental History to include physical and mental health
- Developmental Assessment
 - Gross motor
 - Fine motor
 - Communication skills or language development
 - Self-help and self-care skills
 - Cognitive skills
- Assessment of Nutritional Status
- Complete physical examination
- Medical laboratory tests for lead screening, iron deficiency, cholesterol

CMS permits states to place appropriate limits on a service based on criteria which may include medical necessity. With the exception of EPSDT, there is no definition in the federal Medicaid regulations for “medically necessary” or “medical necessity” although this term is used quite frequently through general Medicaid regulations and guidance materials. This is left up to states to determine. The exception involves children under age 21 who are entitled to participate in the EPSDT program which requires Medicaid to pay for specific screening services as well as diagnostic and treatment services that are necessary to “correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services.” For many states, medical necessity is referred back to the physician’s professional judgment.

Some states have used the EPSDT language in crafting this definition which requires the physician to relate his/her decision to prevent significant illness or disability, or to alleviate pain. It is not uncommon for a State to have a requirement for a physician or “practitioner of the healing arts” to review the IFSP or IEP and sometimes, to sign the IFSP or IEP which indicates medical necessity, or to provide a supplemental document such as a prescription to accompany the plan which meets the medical need documentation requirement.

Requirements for physician “script” for services vary from State to State, with some requiring prescriptions for evaluations or assessments while others don’t, and some requiring “script” for treatment by a specific therapist while not from another specialty area. This requirement is often driven more by State licensure and trade organizations than State Medicaid policy.

Missed Medicaid Reimbursement Opportunities for Washington State 0-3 Early Intervention

Perhaps the most substantial “missed” Medicaid opportunity is reimbursement for Developmental Promotion or Special Instruction for 0-3. The State is using County or Federal funds at 100% to support these services for the total Part C population.

Developmental Therapy or Developmental Promotion is covered as a Part C Medicaid service in at least 28 states, and is typically configured in the State Plan in a variety of ways. The following is Iowa’s definition of this service for children 0-3, which takes a broad approach to defining developmental services (rather than specific therapy services) for 0-3 children. Several other states have implemented this approach as well, which works to equalize all services and promote a more developmental, family and child centered model than a traditional therapeutic one.

Developmental services provided by a licensed practitioner such as early childhood special education, a nurse, occupational therapist, physical therapist, psychologist, social worker or a paraprofessional as delegated and supervised by licensed personnel. Covered services include screening, assessment, service to an individual, and service to an individual in a group. Covered services include identifying the presence of a condition or developmental delay, determining the child’s developmental level of functioning, designing activities that assist the child grow, learn, communicate, and play with others, and meet a specific developmental need.

Another approach is to create Developmental Therapy/Developmental Promotion as a reimbursable service in and of itself, and maintain the current forms for reimbursement for other Part C services (i.e., physical, occupational, speech therapy, etc.). The language in the Maine State Plan includes Developmental Therapy for children 0-5 and defines it as follows:

Developmental therapy providers shall participate in Early Childhood Team (ECT) meetings and in the development of Individualized Family Service Plans and Individualized Education Programs. Time spent in developing the IFSP or IEP may not be billed under this policy and is covered separately by CHILDFIND under the Department of Education regulation Chapter 180 as amended on August 3, 2004 (05-071 CMR Chapter 180). After the child is determined to be eligible under this policy, only time involving face-to-face contact by a therapist with other treatment plan participants in updating the IFSP or IEP may be charged as a collateral service under this policy in accordance with the criteria outlined in Section 27.04-5 below.

Developmental therapy is designed to assist the child in meeting developmentally appropriate goals (or outcomes) and objectives established by the ECT to meet

the unique needs of the child and includes providing the child and the child's family with information, skills, and support, and planned interaction to enhance the child's development. The child must be present for services to be reimbursable.

Developmental therapy may be provided in:

- 1) the home;*
- 2) a community-based setting by an individual developmental therapist providing specialized instruction to one member, as long as MaineCare is not reimbursing for said community setting;*
- 3) a community based special purpose service setting; or*
- 4) an inclusive (or mainstream) service setting.*

Developmental therapy must be provided by an appropriately trained individual for home-based therapy or a community-based special purpose or an inclusive program approved by the Department of Education or its designee as a Developmental Therapy provider according to Section 27.06-3. Developmental therapy will be reimbursed at the provider's contracted rate with Child Development Services. Providers must have a contract with Child Development Services to bill for services and receive reimbursement.

A second "missed opportunity" for the State is that Service Coordination is not covered and reimbursed by Medicaid for all dually enrolled children, 0-3. Service Coordination functions can be performed by a variety of individuals as long as they meet the EI system qualifications for providing this service. Incorporating service coordination as a Medicaid covered service for all dually enrolled children could be achieved for the State's 0-3 EI System in several ways.

The Consultant recommendation is for the uniform inclusion of this service under the EPSDT "Early Intervention" State Plan Amendment rather than pursuing any approach. This is largely due to the state of flux at the federal level in Medicaid regulations and the interpretations of CMS as they relate particularly to service coordination/case management.

A third missed opportunity is the lack of specific reimbursement for desired functions Essential Services and Supports **including travel and transportation costs, preparation, report development and teaming is problematic and has a direct and, consequently often negative, impact upon service delivery.** Collateral contact or "teaming" is typically used to compensate providers when they have a planned, individualized discussion concerning the IFSP of a specific child and is designed to promote information sharing, idea development and enhanced planning to respond to the changing needs of the child and family more effectively. Collateral contact may also be defined to include supportive functions, such as report development, IFSP meetings, family training, etc.

Family members are often (but not always) part of any team dialogue which is conducted in a variety of settings including phone consultation.

If the desire of the State is to promote a consultative model for 0-3 year olds and their families, Medicaid reimbursement should be reconfigured to ensure that these important support services which are directly related to child and family face-to-face direct services are reimbursed by Medicaid.

The use of collateral contact must be made judiciously in order to ensure that the contacts are IFSP-oriented, essential to maintain or advance child and family progress, and – ideally – include the family at all times. Collateral contact is an essential activity if a State is pursuing the implementation of the primary coach model. Collateral contact should be included in the IFSP, linked to the goals/outcomes, with an estimated frequency and intensity of contact. Case note documentation must reflect the purpose and outcome of the consultation. There are multiple approaches to structuring reimbursement to include collateral contact, including separating functions to include a separate category for “consultation.”

The fourth area of potential “missed” opportunity in terms of Medicaid reimbursement is the support that Medicaid provides in several other states which helps to support the system administrative infrastructure – or Administrative Claiming – based upon the total program enrollment in Medicaid. This Administrative Claiming opportunity may be performed at both the State and local levels. Currently in Washington State, the NDCs do access a degree of admin claiming through the Title V agreement.

Administrative Claiming between the IDEA Part C and a State Medicaid program includes a variety of infrastructure or administrative responsibilities that may be coordinated in order to reduce duplication and consolidate effort. The graphic on the following page depicts the variety of individual program components which are shared obligations by both Medicaid and IDEA Part C. For example, both the IDEA and Medicaid are required to conduct outreach to inform and engage potentially eligible children. Both systems require provider standards and methods to ensure that providers maintain licensure or certification, and are appropriately informed of their obligations under each system. For many Medicaid beneficiaries, a plan of care is required; the IFSP serves as this plan of care for children 0-21 under the IDEA. Services in both systems need to be defined, and include appropriate methods for identification (evaluation and assessment).

Both systems have complaint resolution processes for consumers and providers. And, both systems have comprehensive data collection and reporting requirements,

complemented by monitoring and surveillance requirements by the lead agency to ensure regulatory compliance and quality service delivery. Each State's Medicaid and Part C system have a requirement for a council which acts in an advisory capacity.

These components of each State's infrastructure are valued by the State Medicaid agency in terms of ensuring quality, compliance and the ability to report data accurately and in a timely manner. These requirements are designed to ensure early identification, screening, referral and services to eligible children and their families, promote quality services through training and monitoring, address individual and systemic problems through complaint resolution procedures including due process, and promote interagency systems of service that utilize existing resources and supports that reduce duplication and maximize the opportunities for early and sustained, quality health care for its eligible population. These functions qualify for Federal Financial Participation rate (FFP) as "administrative match" at 50% or 75% if provided by medical professionals.

Potential Implications of Recent CMS Proposals RE: Administrative Claiming

The Centers for Medicare and Medicaid Services (CMS) proposed several changes to current regulations which have direct impact upon Medicaid reimbursement for collateral services and, to some degree, some of the activities included under Administrative Claiming. Pursuant to these proposed regulations, any Administrative Claiming initiative would need to ensure that costs of administrative overhead costs are integral to the provision of a covered service.

Federal funding would continue to be available for administrative overhead costs (e.g., collateral contact, as discussed earlier) which are integral to, or an extension of, a specified direct, medical or health care service to the extent those costs are factored into the rate paid for such services and reimbursed at the applicable FFP rate. These overhead costs include patient follow-up, assessment, counseling, education, parent consultations, and billing activities.

Under the proposed rule, CMS would continue to reimburse states for transportation costs related to children who are not yet school-age and are being transported from home to another location, including school, and back to receive direct medical services, as long as the visit does not include an educational component or any activity unrelated to the covered direct medical service.

In part, these proposed changes reflect historical Federal concerns that Administrative Claiming was not used judiciously by some states and that Medicaid payment were made for inappropriate services and activities. Most states have corrected these problems and are now billing properly. While the legitimacy of administrative services

provided by entities other than the state Medicaid agency (the language was fairly specific to public schools) are not questioned by CMS, the proposed regulatory changes reflect "the Secretary's determination that such activities are only necessary for the proper and efficient administration of the State plan when conducted by employees of the State or local Medicaid agency."¹⁴

The implications for 0-3 include the following:

- Any administrative claiming proposals are likely to be scrutinized closely by CMS and need to reflect the concerns represented by this Federal agency.
- There may be challenges to Administrative Claiming by CMS if other third party resources are reflected within the State's System of Payments for Part C because non-Medicaid participants do receive these services at no cost including the use of their private resources (e.g., private health insurance and family cost participation).

Section 411(k)(13) of the Medicare Catastrophic Coverage Act of 1988 (MCCA) amended section 1903(c) of the Act to clarify that Federal Medicaid payment is available for otherwise covered services furnished to children in fulfillment of requirements under IDEA. Specifically, section 1903(c) of the Act, as amended by the MCCA, prohibits the Secretary from denying or restricting Federal Medicaid payment to states for covered services furnished to a child with a disability on the basis that the services are included in the child's Individualized Family Services Plan (IFSP) established pursuant to the IDEA.

Summary of Options and Opportunities

Ideally, the approaches to enhancing or maximizing Medicaid are achieved in a consolidated, streamlined manner which results in a comprehensive and easily accessible system encompassing all services for dually eligible children. This approach helps to ensure administrative ease and reduces the opportunity for problems (e.g., documentation, denials, double-dipping, fraud, etc.) later on.

Recommendation: EPSDT Services

For the purposes of this next discussion, we will be focusing on one singular approach to accessing Medicaid for the EI population: EPSDT Services.

While there are several options to consider as a state reconfigures Medicaid for any population, key considerations from a public policy perspective include:

¹⁴ CMS NPRM: Elimination of Reimbursement under Medicaid for School Administration Expenditures and Costs Related to Transportation of School-Age Children between Home and School, page 10.

- Ease of management at state, local and provider levels, particularly in terms of accessibility, documentation and monitoring/surveillance;
- Cost projections – figuring out the potential impact (people and funding) for state consideration;
- Continuity of care for individuals as they “age” from one public system to another, or when eligibility changes and service needs continue; and
- Adequate capacity or availability of appropriately qualified providers.

Given the many changes happening at the Federal Medicaid level related specifically to the regulatory process, the following single recommendation is made for the 0-3 System in Washington State.

Create a New EPSDT Service Category: Early Intervention Services

As discussed in earlier, EPSDT ensures the provision of needed covered services to eligible children as well as access to those services not in the State Plan but which are identified as a result of a screening. States often refer to these services as “out of plan” services. When an EPSDT screen “triggers” such a service, the State Medicaid agency is obligated to provide this service even if they have no provisions which establish appropriate provider qualifications, reimbursement rates, etc. CMS has encouraged State IDEA programs for several years to establish services through EPSDT for dually enrolled children to ensure that they would receive all of the early identification and treatment services which they need.

By filing a State Plan Amendment (SPA), the State would create a new service entitled “Early Intervention Services” within EPSDT to include all EI services, which would be reimbursed according to the following five (5) service categories for all 0-3 practitioners:

- **Screening or Assessment** services including: Newborn, infant, toddler comprehensive developmental (Gross motor, Fine motor, Communication skills or language development, Self-help and self-care skills, and Cognition), vision and hearing, physical and health.
 - It is also required that children receive a Comprehensive Health and Developmental History to include physical and mental health. This activity closely mirrors the “intake” that is performed for all children once referred to Part C.
- **Multidisciplinary Team Services** would include Evaluation for Eligibility, IFSP team meetings, consultation (collateral services) to primary provider as appropriate for individual children
- **Early Intervention Services** (direct and related child and family services) for 0-3 Year Olds

- **Transportation and related costs** necessary for the child or family to receive a service.
- **Service Coordination/case management**

All EI services would be included in this chapter:

Assistive Tech.	Psychological
Audiology	Respite
Family Training	Service Coordination
Health Service	Developmental Promotion
Medical Diagnostics	Social Work
Nursing	Speech-Language
Nutrition	Transportation
Occupational Therapy	Vision
Physical Therapy	Other Needed Services Per the IFSP

This SPA for the 0-3 EI system would utilize appropriate (and often common) provider qualifications across the two programs, common service descriptors and common rates to promote the provision of EI services in home and community placements. Utilizing this approach would consolidate all EI Medicaid reimbursement into one Medicaid chapter, making it easier to track the delivery of services, isolate State “match,” and monitor for quality and compliance.

This approach offers considerable flexibility and would permit inclusion of a variety of community public and private providers, thus expanding options for “natural environment” and LRE requirements. This would require a revision in the provider qualifications which currently exist in both programs to include, for example, other early childhood providers such as Early Head Start, Head Start, child care, etc. Upon meeting the provider qualifications, these individuals would be reimbursed for IFSP services provided during the child’s participation in the community program or service. These individuals would be considered members of the IFSP Teams and would receive appropriate supervision in conducting these activities based upon the child and family needs. It is important to note that covered EI services are strategic and individualized planned activities in concert with the IFSP with a child and family, focusing on one or more of the child’s developmental domains, and are not intended for their general participation in the community program or service.

If desired by leadership, this EPSDT initiative could permit a “levelized” approach to personnel, reimbursing personnel in a non-traditional approach by using three categories (example): Early Intervention Specialists, Associates and Assistants. Specialists are

typically four (4) year or more degreed individuals, while Associates represent two (2) year degreed and Assistants are less than this but at least a high school diploma or GED.

The use of the latter categories (Associates and Assistants) ensures the inclusion of personnel in community programs who have completed the appropriate training and are properly supervised in the implementation of the IFSP for individual children. This approach also controls for quality by restricting certain functions (e.g., assessment) to individuals with higher qualifications and specialized training.

CMS does not support reimbursement for Service Coordination when these functions are provided by a practitioner who also provides another covered service. The public policy decision for Washington State is WHAT kind(s) of Service Coordination best fit the ITEIP system:

- **Independent** – in this approach, service coordinators are separate from the service provider entity/agency system and do not perform any other EI function.
- **Dedicated** – in this approach, service coordinators are integrated into the EI service provider entity/agency system (e.g., employees or contractors) and do not perform any other EI function.
- **Blended** – in this approach, service coordinators are also EI service providers. They may work in EI agencies or be private, independent contractors.

One, two or all three approaches may be employed in an EI system. If the “Blended” model is desired, the State needs to recognize that this approach would not be reimbursed by Medicaid. Other funds (State or Federal) would need to be identified to reimburse for these services for Medicaid enrolled children. Clearly all three models are useful and can co-exist, permitting individualization and flexibility at the local level. For children who are not Medicaid covered, parallel criteria and reimbursement would be established through County, State or Federal funds.

Considerations and Next Steps for Decision Making

There are several decisions that Washington State must make before proceeding. These are public policy decisions and directly relate to the issue of quality services for children and families. The decisions will determine which option(s) is most desirable to utilize. Decisions include:

- What will the definition of collateral contact actually be? Will it encompass consultation, IFSP meetings – or will these be separate activities? Other successful State models provide a variety of examples and options for consideration.
- Will consultation be part of collateral service, or embedded in the direct service category?

- Is there a reasonable or desirable “limit” to collateral contact that should be established (e.g., a maximum or “cap”).
- Will collateral reimbursement be available to all providers or more limited based upon the State’s provider qualifications and supervision requirements?
- Does the administration want to expressly collect data related to the frequency, intensity, etc., of collateral contact, or consultation if it is defined separately?
- Is differential reimbursement desired for this service?

Medicaid State Plan Amendments focusing on 0-3 should be written in such a way as to maximize the EPSDT language and connections with the comprehensive developmental approach of services for eligible children ages 0-3 and their families.

One State example where “collateral service” is specifically reimbursed through Medicaid, defines this service as “teaming”, as follows:

Definitions/Activities

The (discipline or specialist title) as a member of the child’s IFSP team, may participate in team planning meetings. Participation includes face to face and any real time electronic means of team communication with other team members and the family, to plan, design, develop, and review activities to meet the child and family’s needs, including, but not limited to, eligibility meetings, and the development and evaluation of the IFSP document.

Activities include:

- *Multidisciplinary evaluation team meeting with family/caregiver to determine eligibility for State’s Early Intervention System;*
- *Assessment planning activities;*
- *Individual Family Service Plan meeting with intervention team and family to design/review appropriate outcomes and objectives, identify intensity, frequency, duration and location of services and to plan for transition; and*
- *Problem solving intervention strategies, including AT strategies, among the team members, including the family.*

Maine also reimburses for collateral contacts for 0-5 services, under all funds including Medicaid, using the following definition:

Collateral Contacts

Collateral contacts require face-to-face contact by a therapist with professionals included in the treatment plan to discuss the member’s case for the purpose of coordinating services and ensuring the most appropriate mix of services for the member.

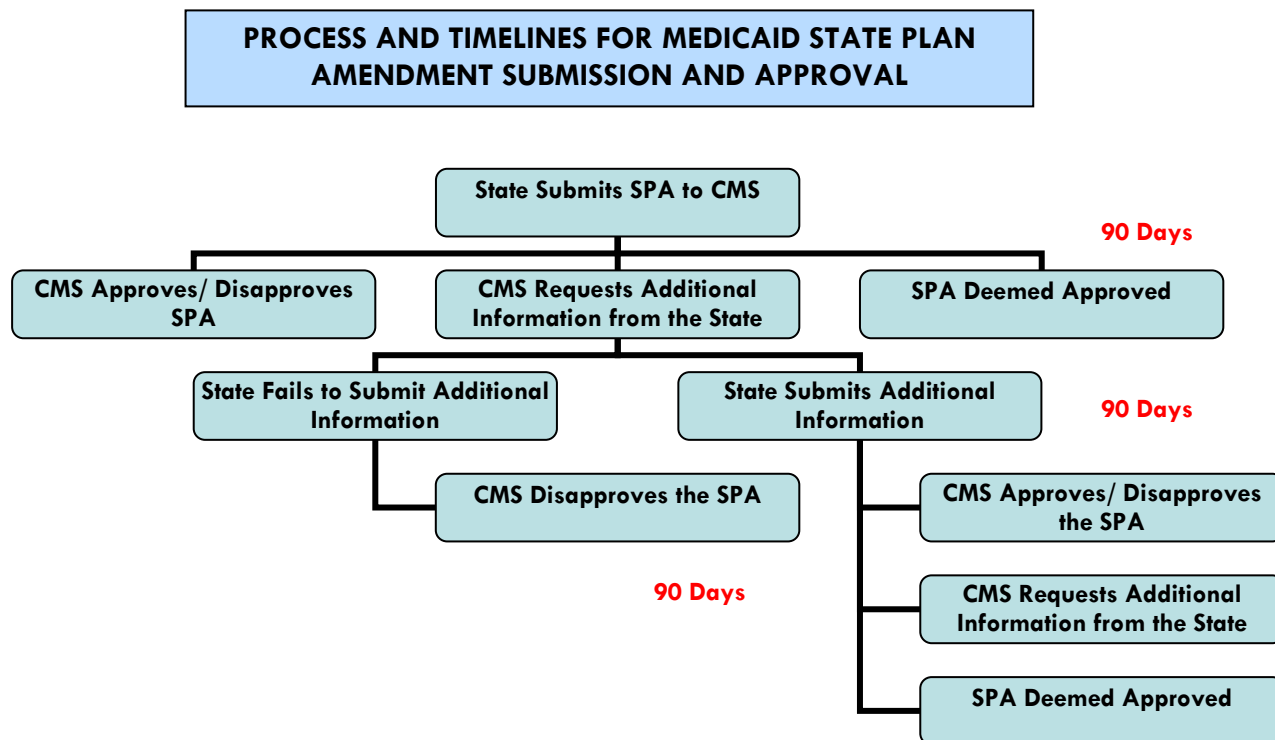
Discussions between staff of the same agency or clinic or contracted agency or clinic are not considered collateral contacts, unless the discussion is the result of a

team meeting, which also includes professionals and caregivers not employed by the same agency or subcontracted agency or clinic. The billing provider can request reimbursement for only one servicing provider per collateral contact. Collateral contacts shall not be billed to the Department until the Early Childhood Team has convened and developed an Individualized Family Service Plan, or an Individualized Education Program on which a collateral service is listed as a required service, signed by the primary health care provider and the parent, guardian or surrogate parent. A separate collateral contact shall not be billed to the Department when provided on the same day that the Department is also billed for the provision of a session of Developmental Therapy.

Currently the 0-3 Part C system in Washington State does receive Medicaid reimbursement for collateral contact. One approach is to include reimbursement for this service in the general, over-all rate of reimbursement by providers. When a unit of direct service is delivered, there is a consideration of some collateral (telephone, meeting, e-mail) consultation within the reimbursement for the face-to-face service. This approach places a less than direct emphasis on the desired outcome – that is, to ensure that teams are communicating, families are involved in all aspects of the service delivery decisions, and duplication is reduced while skill enhancement is happening for all practitioners through the team model.

Another approach to consider which would include collateral contact/teaming as a reimbursable service is to have a “tiered” approach to reimbursement by establishing a “lead” or primary provider for each family responsible for the ongoing service delivery and integration requirements of the IFSP. Secondary or supportive team providers would have clearly defined roles to include assessment, team meetings and consultation to include team and the family individually. The definition of covered service would include all of the functions of direct service and teaming with the specificity of frequency, intensity and duration individually listed by provider on the IFSP. The IFSP would clearly display who the “lead” or primary provider is by virtue of the intensity of services, whereas the “secondary” or “supportive” team members would have significantly less frequency of services anticipated. This approach would have to be reinforced through intensive training and monitoring to promote teaming, role release, individualized application of the model, etc.

Next Steps/Timeline



The effective date of a new State Plan Amendment may not be earlier than the first day of the calendar quarter in which an approvable plan is submitted.

If this is the course of action that leadership chooses, the next steps would include:

- Identify the qualified providers:
 - Create a crosswalk between the current provider qualifications for Part C and Medicaid, identifying commonalities and differences.
 - Determine if there will be different “levels” of practitioners for the five (5) specific functions identified.
 - Determine if other providers will be included in this initiative; if so, include them in the crosswalk.
 - Using the five (5) functions of service, identify which qualified providers can perform each of these functions.
- Determine the current amount of State “match” being used to support all enrolled Medicaid children for their EI services and supports. Any additional “match” requirements would need to be negotiated between ITEIP and the State Medicaid agency. The current level of state “match” must be preserved.

- It is not uncommon for State IDEA lead agencies to provide the State “match” for traditionally uncovered services (e.g., Developmental Promotion, Service Coordination) or for them to provide the “match” for the additional costs incurred in the provision of services in the natural setting/least restrictive environment.
- It would not be appropriate for ITEIP to match traditional “medical” services as these are the clear obligation of the State Medicaid agency whether or not the State participates in the provision of the IDEA services.
- It is possible that County funds could serve as “match” for the more non-traditional services designed specifically for Part C such as Service Coordination and the constellation of developmental services provided emphasizing daily routines and activities in the child and family’s home and community – or typical – settings.
- Develop the State Plan Amendments for submission to CMS (one each for Medicaid and SCHIP). Each State has its own protocol and preferences in SPA development.
 - Some states prefer to work collaboratively between the Medicaid and EI agencies, developing the SPAs jointly.
 - Still others develop the SPAs jointly and involve the regional office of CMS in informal discussions and review of each SPA as it is developed.
 - Still other State Medicaid agencies prefer to develop the SPAs independently of the EI agency, and will consult with them during development for verification and guidance purposes.
 - A few State Medicaid agencies have deferred SPA development to the EI lead agency and provided technical expertise during the process, which may include informal CMS participation.
- There are significant systemic considerations as any system changes are made. If this option is selected, it would involve nearly all other components of the Part C system. These include but may not be limited to:
 - Review and make modifications in the training and technical assistance manuals and materials.
 - Review of all system documentation including, most particularly, the IFSP documents, evaluation and assessment documentation, etc.
 - Review monitoring and supervision protocols for appropriate modifications, including documentation, inclusion of new providers, etc.
 - Adjustments in the allocation formula to localities for non-third party funded services.
 - Development and dissemination of informational materials and briefing sessions to adequately inform key stakeholders and families about the

pending changes and benefits to the system as a whole, and to families and children individually.

- o Review ITEIP data system to be sure that all appropriate system modifications are made to accurately link documentation to data entry, ability to produce routine State and locality management reports, etc.

Summary of Programmatic and Fiscal Benefits for the State

The universal approach through EPSDT to cover all 0-3 Early Intervention Services provides a single reimbursement mechanism for all IFSP services, and permits the State to streamline provider qualifications and enrollment, training, and service delivery for all children – creating a seamless 0-3 service delivery system. The anticipated new revenue would be substantial for the ITEIP system and should create a stable, long-term financial foundation that, when coupled with state funds, will enable the State to ensure funding for needed services for all eligible children in an equitable and consistent manner throughout the state.

While the ITEIP system does not have a state fund allocation, the local counties do receive state and/or county public funds which could be used for Medicaid “match” utilizing a certification of match agreement. The offset in terms of how these funds are currently utilized to support non-third party services would vary from locality to locality, and may not be an option for localities that do not provide county or state public funds to support Part C. This would need to be assessed by the ITEIP Lead Agency.